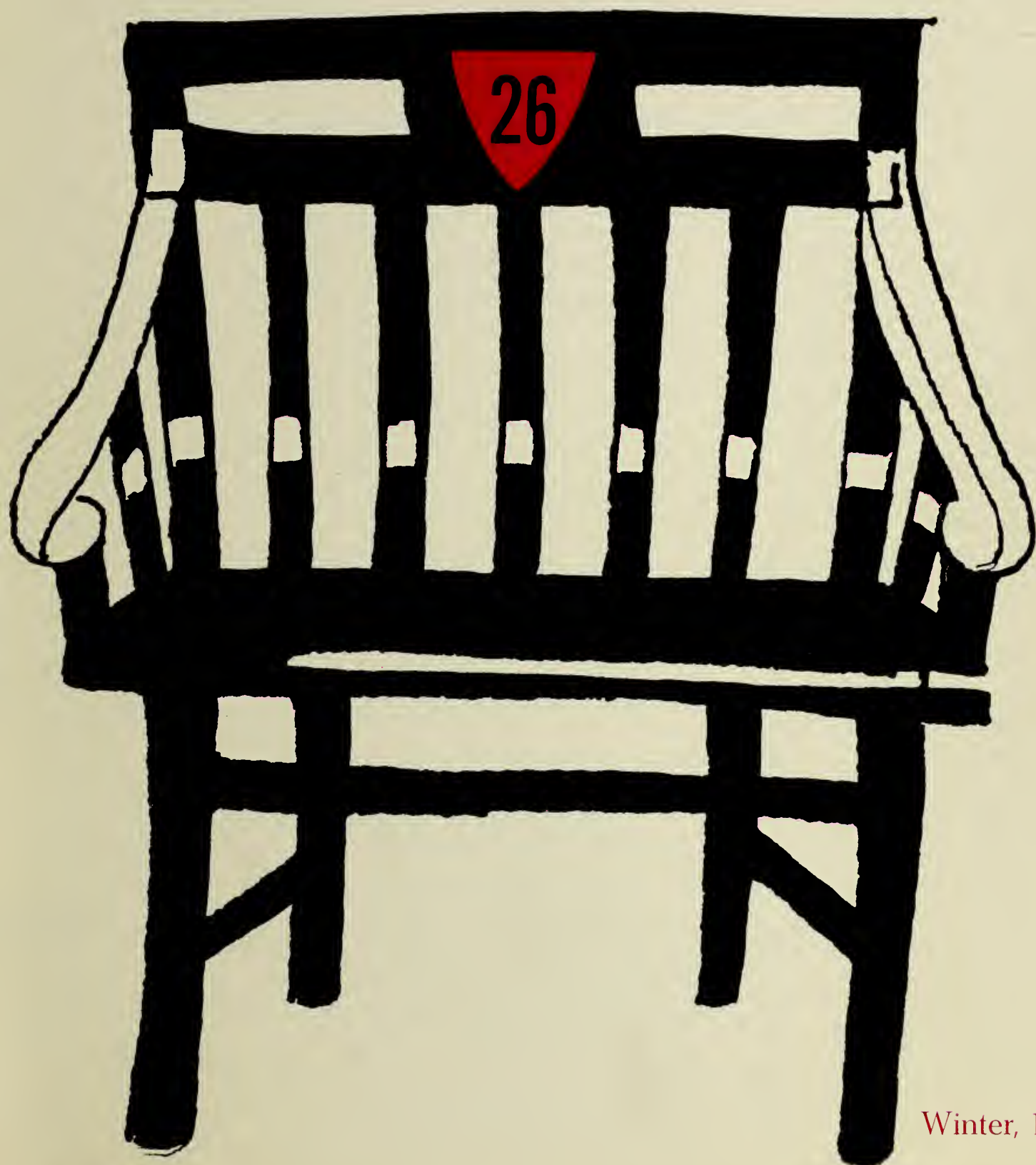


Harvard

Victor
MEDICAL
ALUMNI
BULLETIN



Winter, 1966

LETTERS

Why is Psychiatry Still a Specialty?

To the Editor:

I was interested to learn of the changes taking place in the medical curriculum of the Harvard Medical School described as an "Introduction to the Clinic" in the Christmas 1965 issue of HMAB (pp. 4-7). One of the important reasons given for the change was to eliminate the "considerable wastage of time" in the past and to provide "basic clinical fundamentals."

The Principal Clinical Year is divided into three four-month semesters;* medicine, surgery and the specialties. Thus, psychiatry is regarded as a specialty and must perforce receive considerably less time than medicine and surgery. On the one hand there is the impetus to concentrate clinical work with the implication that early contact with the living patient is desirable and on the other hand a basic significant approach to the patient, as a person and a human being, is taught within a specialty (psychiatry).

As a psychoanalyst, who teaches psychiatry, raising the question as to why psychiatry is not considered as a major discipline along with medicine and surgery may imply the usual bias of the specialist for his own field of endeavor. If the medical student is to become primarily a good capable physician, a knowledge of human behavior is absolutely essential. An understanding of human motivation and the complexities of personality are as necessary to the practice of medicine as a knowledge of the basic sciences are to medicine and surgery.

At the Beth Israel Hospital, under the leadership of Dr. Grete L. Bilbring, medical psychology was taught to the medical students, interns and residents as a fundamental approach to patients as human beings. Those professional personnel trained in this manner were prepared

to deal with their patients, as individuals, who had medical or surgical problems.

With the increasing complexity of life today, and with the need for physicians to transcend individual considerations to include economic and social factors, a grounding in medical psychology obtained in psychiatry will become an essential ingredient of the armamentarium of the physician whose primary aim is to treat sick people and not necessarily specialize in research.

Thus, I would like to understand why psychiatry is still presented as a specialty in the curriculum of the Harvard Medical School.

JOSEPH J. MICHAELS, M.D.
Clinical Associate in Psychiatry
Harvard Medical School

1846 Letter Labels Dr. Morton a Quack

To the Editor:

I was much interested in the recent article in the *Alumni Bulletin* on "The Forgotten Man in the Ether Controversy."

My grandfather, J. D. Mansfield, was a general practitioner in South Reading, now Wakefield, at the time of this controversy. I think the following letter he wrote to the Editor of the *Boston Medical and Surgical Journal*, dated November 10, 1846, and published December 23, 1846, Vol. 35, p. 424, may interest your readers. It brings out certain ideas held by the medical profession at that time.

Sir:

I was much pleased in perusing a paper in your Journal of last week, by Dr. Flagg, of Boston, on the inhalation of ethereal vapor in certain cases requiring surgical operations; and I am happy in being able to say, that his views are those of the profession generally in this region, so far as I have been able to learn their opinions. It seems to us not only ridiculous, but absolutely wrong, for any physician to adopt a course of action so entirely contrary to the spirit of the rules of the Mass. Medical Society, and to those high and just principles which have generally governed the members of our profession.

If Dr. Morton *has* really made a new discovery, let him be contented to stand on the same footing with *other* physicians of equal merit, who have made

many and important discoveries in medicine and surgery; and let the consciousness of having done a good deed for humanity, the gratitude of an intelligent community, and the praises of a liberal profession, be a sufficient reward, without a desire, on his part, to make a fortune at the expense of "suffering humanity," and of all just rules of our profession.

Why did not Dr. Stearns, when he discovered the medicinal properties of ergot, get the right of using it patented, and allow no one to use it, but those who bought the privilege of him? Why have not a hundred similar discoveries in medical science, been patented ere this? Why? Because there has been, and I hope always will be, too much honor in the medical profession to allow such a course of conduct, in any one of the members.

Does anyone suppose that he will be able, by a brazen front, and threats which are so freely thrown into the market, to intimidate the profession, and prevent them from using a well-known medicine, when, how and where their judgement may dictate. If so, I think that gentleman, whoever he may be, will find himself egregiously disappointed. Physicians in this vicinity, I am satisfied, will use the ether if they have occasion so to do, previous to dental or surgical operations; and if ether alone does not answer the purpose, they can easily find, I think, a compound that will do as well as the patented vapor.

While spending an evening a short time since, in a social party, composed mostly of literary friends, the inhalation of an ethereal compound formed a part of the amusements of the occasion. The compound used in this case was composed of sulphuric ether, water and morphine with a few drops of diluted sulphuric acid. This mixture was inhaled through a common retort, with a ground stopper at the apex of the globe. The effects which it had on those who inhaled it were similar, if not identical, with those produced by the vapor now so much in vogue. One young lady, in particular, came so completely under the influence of it, that, had she an aching tooth, I think I should have tried my skill at extracting. I do not know, however, as this compound has any advantages over the ether alone. I doubt, myself, whether it has, for this substance has been long known to have those peculiar effects ascribed to the "new vapor." On this point, however, every physician can satisfy himself by a few simple experiments, and will, without doubt, find a substance that will satisfy all practical purposes, and that, too, without being obliged to sacrifice his professional dignity, by patronizing quackery.

J. D. Mansfield
South Reading, November 10th, 1846

ERNEST M. DALAND '18
Boston, Mass.

* Editor's Correction:

The HMAB article, "Introduction to the Clinic" said the Principal Clinical Year was divided into three four-month semesters, this should have read, *four three-month* semesters.

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The opinions of contributors to the Bulletin do not necessarily reflect those of the Editorial Staff.

EDITORIAL

“And Gladly Learn”

One of the most important functions that a Faculty of Medicine performs is the selection of young men and women desirous of entering the medical profession. Establishing proper criteria for choosing these individuals should not be too difficult. One is reminded of the dilemma that faced the highly intelligent and efficient Florence Nightingale over 100 years ago, in selecting volunteers for the task of military nursing along the shores of the Bosphorus. According to Sir Edward Cook, who wrote her monumental biography, she cut across social and religious ties and “applied only one kind of test to a nurse: was she a good woman, and did she know her business.”

In general, the same criteria should apply to a candidate for medicine. If he is to withstand the intellectual rigors of undergraduate and post-graduate training today, and if he is to keep informed about the rapidly changing scene of medical science after he is out in practice, he should be a scholar who pursues knowledge and gladly learns. The absolute necessity for a doctor to continue his education on his own initiative as long as he is active in medicine should cause entrance committees to scrutinize carefully the academic background of the premedical candidate. The doctor of tomorrow who fails to keep up with the advancements of medical science and the challenging social aspects of medical care will wither on the vine in a few short years. Since World War II, the upgrading of scholastic requirements in schools has led to highly qualified candidates. One has reason to be optimistic about the future status of doctors as scientists, but somewhat doubtful at times about their attitude toward the complex social problems of society as they relate to medical care. It is in the latter field that medical leadership is urgently needed.

Medical educators are taking a good look at the relation of the medical school to the community as a whole. This interest has stemmed largely from an emphasis on preventive medicine, on the emerging recognition of the behavioral sciences, and on the rising costs of medical care. This signifies that more attention will be given to the care of ambulatory patients and to teaching in outpatient services. The inter-hospital relationship in a community or region will be cultivated more intensively.

A university hospital and medical school is obligated to society to alleviate human suffering and to eradicate disease through research. But the readily available research grants have a tendency to support too much mediocrity at the expense of teaching responsibilities. Research will not abate, but perhaps a more critical appraisal of its place in medical schools will take place. Competent investigators must be supported, and they are often the most capable teachers. Increasing the staff and shifting mediocre people to teaching assignments will not lead to excellence in training doctors. There are other methods for resolving the dilemma, but this in-

volves the well trained individuals in practice who can effectively participate in teaching on a part-time basis.

But today's demands and responsibilities made upon the full-time clinical teacher are at times almost unbearable. Not only is the medical student confronted with a mass of knowledge but so are the teachers and they must keep up with significant new information. They are expected to have a broad and deep understanding of their specialties, and they must be articulate and incisive in communicating their knowledge; they are charged with the care of patients; their academic stature and advancement often depend upon creative research activities; and, acting as administrators, their time is further robbed.

The established procedure of using competent practitioners as part-time clinical teachers sometimes leads to mediocrity in teaching. Not receiving remuneration for their academic responsibilities, these practitioner-teachers perforce think first of the requirements of their practice. This is understandable. These individuals, however, are caught up in a vicious circle. Attachment to a teaching unit with academic status leads to further professional recognition and in turn to additional professional demands. Perhaps the time has come to give up honorary appointments without remuneration for the part-time clinical staff and to acquire a group of highly competent clinicians having appropriate academic rank with a respectable salary that will tie them to their clinical, teaching responsibilities. There should be ample room for highly qualified young men as well as for the more experienced doctors. Perhaps it would be wise to have more private and public funds assigned to such an enterprise, thus providing additional time for a smaller, but excellent, number of investigators.

Can a busy practitioner on a part-time teaching assignment still make pertinent contributions toward the advancement of medicine in an age of molecular biological research? The answer, of course, is yes. There will always be an opportunity for the inquiring and inquisitive doctor. It is, after all, from him that the student receives an understanding of patient care that no other person could give him.

Continuing education of the doctor is a recurring theme. His opportunity to learn has never been greater and if he has been properly selected for the study of medicine he will gladly learn.

Wesley W. Spink '32

Much of the above appeared as an Editorial in the *Australasian Annals of Medicine*, June 14, 1965.

Growing Pains

The Story of the Program for Harvard Medicine



by

Laurence O. Pratt

Program Manager

Mr. Pratt has told the story of the Program for Harvard Medicine in his usual excellent fashion, dealing factually not only with the achievements, but also with the complexities and frustrations that were necessarily involved when nine institutions joined in a collaborative effort. In highlighting the various factors that brought the Program to a successful conclusion, he has omitted one of the most vital—himself. I take great pleasure in giving credit where credit is due—in expressing tremendous indebtedness to Mr. Pratt for his comprehensive understanding of the Harvard Medical Center and for his imagination and endless patience in guiding the activities of the many individuals and groups involved.

GEORGE PACKER BERRY, M.D.
Former Dean, Faculty of Medicine and
Professor of Bacteriology, Emeritus

On January 20, 1966, The Program for Harvard Medicine, called in its earlier days the Harvard Medical Center Fund, announced the achievement of its \$58 million goal after nine years of effort. Some \$54 million had been recorded in gifts, pledges and bequests. Wise investment by the Treasurer of Harvard University made possible the assignment of more than \$4.1 million in net taken gains. Additional gifts resulting from requests for grants still outstanding are confidently expected in the months ahead.

As most readers of the *Bulletin* know, the purposes of the Program, as set forth in the agreement reached by the Medical School and the Associated Teaching Hospitals in 1956, were stated to be "strengthening the academic purposes of the Faculty of Medicine in the Harvard Medical School and the Associated Teaching Hospitals," including construction and endowment of "a library at the Medical School to serve more adequately the entire medical community." The Francis A. Countway Library was completed and dedicated in formal ceremonies in May 1965. In the basic sciences and clinical departments the faculty has been enlarged and strengthened; 40 new full-time tenure appointments have been added and 11 tenure positions, presently unfilled, are now being considered by ad hoc committees; and 26 fully endowed named professorships have been created.

This happy result was the culmination of a long series of events extending back to the year 1947. The story and the honor roll of those who contributed to it are long—too long to do justice to them here. With apologies, a brief summary of the three main phases is presented: First, the steps leading to the formation of the Harvard Medical Center that was to set the stage and establish the ground-rules; second, the beginnings under the banner of the Harvard Medical Center Fund; and third, the major effort, known as the Program for Harvard Medicine.

EARLY STEPS

The story starts with the Committee on Resources and Organization appointed in 1947 by President Conant and composed of eight senior members of the Faculty of Medicine, the Dean, and the President and Administrative Vice President of the University. Following their report, a Standing Committee, consisting of the President of the University, the Dean of the Faculty of Medicine and the

presidents of the boards of trustees of the Teaching Hospitals, was appointed "to formulate long-range plans and to turn these plans into reality."

The long negotiations were borne of necessity in view of the desperate situation in which Harvard Medicine found itself at the end of World War II. The endowment at the School and the Teaching Hospitals for the support of the Faculty of Medicine had been eroded by inflation during the war years. Meanwhile, public expectation had undergone a profound change. Better health was no longer to be considered a privilege but a basic human right. The nation had been deeply impressed by the Manhattan Project, and believed that a similar massive attack in the biological sciences would yield miracles of discovery, ending at last the threat of cancer and other dread diseases. Henceforth, the growing participation of Uncle Sam in fostering medical research was a foregone conclusion. If Harvard and the Associated Teaching Hospitals were to continue in their traditional roles of leadership while preserving their academic freedom, another major forward movement was clearly called for.

By January 15, 1953, the broad concepts of the Harvard Medical Center were well advanced after long and complex negotiations. The date marked the last meeting of the Standing Committee attended by President Conant. He stressed forcefully his belief that *closer integration and cooperation* was essential to the progress of both Hospitals and School.

To achieve this goal, a "Grand Design," as the members of the Committee affectionately called it, was already emerging. Great faith was placed in the idea that a new coordinating agency could, through a combined fund-raising effort, remove any problems of divided loyalties and draw the entire enterprise together into an effective whole. Dean Berry who henceforth was to represent the University on the Standing Committee noted that success could be achieved based on the great appeal of the Hospitals for financial support of *patient care* and *community service*, and of the School for financial support of *education* and *investigation*. The Dean went on to stress the complete interdependence of the two. All participants were to recognize the joint responsibility for the total program. Mr. Conant's parting injunction was, "Get on with the plan."

During the next three and one-half years, the members of the Standing Com-

mittee worked at a demanding pace. Proposed by-laws and legal documents had to be drawn up. Dean Berry and Mr. Henry C. Meadow, Associate Dean for Financial Affairs, were deeply immersed in studies of the academic requirements in the basic science and clinical departments of the School. Since the original concept of the Grand Design included all the capital needs of the participating institutions, the Hospitals, too, were engaged in drawing up estimates of their building plans over the next decade as well as their capital requirements to support the academic program.

Two problems presented special difficulty, and the members of the Committee discussed them again and again. First, according to an early estimate of the Standing Committee, \$150 million was the amount needed for buildings and academic purposes. Although this amount was reduced by \$25 million by eliminating all duplication, a goal of \$125 million seemed unrealistically high. Even if a sum so large could conceivably be achieved, consideration had to be given to the effect on Harvard College which was also in the process of planning a capital campaign. It would have been unthinkable to announce two such precedent-breaking efforts simultaneously. These were some of the considerations that led the Standing Committee to agree at their July 23, 1956 meeting that the Hospitals and the Medical School individually should seek the funds required for buildings and operations. Through the Harvard Medical Center, they would work together to raise money to strengthen the academic purposes of both the Medical School and the Associated Teaching Hospitals and construct and endow a library to serve the entire medical community. The goal for this joint undertaking was set at \$58 million.

Practical considerations made this decision necessary, but it was to add to the difficulties of achieving the kind of integrated effort that Mr. Conant had envisioned, as the members of the Committee were the first to realize. Raising \$58 million dollars, mostly for endowment, was not an easy task under the best of circumstances. It was unreasonable to expect Hospital boards, plagued by continuing deficits and faced with space requirements that were both imposing and urgent, to set aside these immediate concerns in favor of a joint campaign that seemed to them more remote. While the members of the Standing Committee were to give their stead-

fast support to the Harvard Medical Center throughout the undertaking, it was inevitable that the campaign of necessity was to become University-oriented. Meanwhile the Medical School deferred its efforts to secure resources for urgently needed buildings, believing that the academic requirements merited top priority.

A second problem—it was discussed in all its ramifications through the years from 1956 to the conclusion of the campaign in 1965—was how to allocate prospects for substantial gifts to the participating institutions. All recognized that a well-to-do prospect, whether individual, foundation or corporation, represented an important asset. Some of the members of the Committee felt that the interest of the prospect himself should be the deciding factor, but who should decide in advance what these interests might be? Only one solution could be found. The Committee decided that prospects living in Boston and an area roughly defined as within fifty miles of the State House, were not to be cultivated by the Harvard Medical Center in an *organized* way. Although no one was completely satisfied with this arrangement, all thought it might be modified with further mutual experience.

The objective was to reserve the area for the Hospitals which were, of course, heavily dependent on grateful patients for their financial support. The agreement was an informal one, and the members of the Standing Committee left the door open to exceptions whenever the interests of a prospect were strongly oriented toward teaching and research at the Medical School. This geographical restriction was faithfully followed during the nine years of the undertaking, except for the Harvard Medical School Alumni campaign, specifically authorized by vote of the Trustees.

As the stage was being set for the curtain raiser, one further difficulty was to arise. At the September 18, 1956 meeting the seriousness of a possible conflict of interest with the Program for Harvard College, was discussed. Mr. William M. Rand, Harvard College '09, who had already been selected as General Chairman for the Medical Center Fund, reported to the members of the Committee the results of a meeting with Mr. Pusey. Mr. Rand noted that the campaign for Harvard College hoped to secure \$85 million, making it the largest single college fund-raising effort ever to be undertaken. On September 24th, in a

meeting attended by Mr. Pusey, Dean Berry, Messrs. Charles A. Coolidge, Ralph Lowell, William M. Rand, James R. Reynolds and Alexander M. White, General Chairman of the Program for Harvard College, a working relationship between the two efforts was agreed to. The Harvard Medical Center was to be free to solicit certain medically oriented corporations, foundations and individuals after clearing the names with the President's office.

It is to the credit of those who participated in this meeting that such an accommodation was reached in a spirit of cooperation and understanding. And, a special tribute is due those who had given so generously of their time and talents for so many years to create the Harvard Medical Center. They never faltered in their determination to move ahead. They were to concentrate during the next four years—without publicity or fanfare—on a few medically oriented prospects capable of making very substantial gifts.

The new federation was ready to be launched.

PHASE 2 THE HARVARD MEDICAL CENTER FUND 1956-1960

The first meeting of the Harvard Medical Center Trustees was held on September 26, 1956. Their earliest concern was to identify prospects for substantial gifts, and secure clearance from the President's office. That they chose well in pinpointing a relatively few individuals and foundations for their special attention the results were to prove. In the period from September 1956 to June 30, 1960, \$17,514,301 was raised in just 47 gifts, pledges and bequests. Of these, seven gifts were for a million dollars or more, including the largest gifts received from a foundation and an individual during nine years of effort.

Although the Trustees of the Center all played a part, the period was largely a saga of three individuals: Dean Berry, General Robert Cutler, Vice President of the Medical Center and Chairman of the Board of the Peter Bent Brigham Hospital, and William M. Rand, the General Chairman. Some measure of the devoted service of General Cutler can be gained from the single proviso he attached to his acceptance of President Eisenhower's invitation to direct the Inter-American Bank: He must be free to continue his

work for the Harvard Medical Center Fund.

An outstanding achievement of the period was the assurance of the Library through the magnificent irrevocable trust created by Miss Sanda Countway for \$3.5 million. The gift provided great encouragement during the early, difficult days. If it may be said that this success resulted primarily from the persuasive powers of Dean Berry (an attribute that was to be the mainstay of the campaign from start to finish), it is equally true that Miss Countway derived enormous satisfaction during the last years of her life from the insights he gave her of the key role the Library was to assume in the advance of Harvard Medicine. It was tragic she was never to see the magnificent building.

Aside from the impressive achievement in fund-raising, the Medical Center Fund laid a solid foundation in a number of other ways. It was a time of planning, research, writing—and bold experimentation. A small staff was preparing information in depth about the extraordinary academic record of the Alumni of the Medical School throughout the world. For the first time, similar data was assembled about those who had received a substantial part of their post-doctoral training in the Associated Teaching Hospitals. The information was basic to the case later to be presented to foundations and individuals throughout the country. One question was inevitably asked by every prospect! "Why should we contribute to Harvard Medicine when our own local medical school is asking us for help?" The answer: "The Harvard Medical School and the Associated Teaching Hospitals have trained a disproportionate and impressive share of the academic leaders in the nation. How can you expand your school—how can the required additional physicians be trained if this wellspring of teachers is permitted to run dry?" The statistics were supplemented with the names and academic positions of the Alumni—a method of presenting the data that proved to be most effective.

Experience was being gained about the problems of approaching foundations. Although Dean Berry's active participation on the boards of two important foundations was a great help, relatively little was known five to ten years ago about foundations, their individual policies and available resources, and how best to approach them. It was not until 1960 that the first *Foundation Directory* was published by the Russell Sage

Foundation.

This will make clear why one success had a significance far out of proportion to the size of the gift of \$200,000 from the John and Mary R. Markle Foundation. Most of the health-oriented foundations gave as a matter of policy only for current use, shying away from gifts to capital campaigns. The Markle Foundation was no exception—its fellowship program was recognized as a notable contribution to medical education. When the Trustees of this Foundation, so respected for its pioneering, made an exception in view of the importance they attached to the Harvard Medical Center appeal, their action constituted a significant milestone. Their example was to be reinforced four months later by a gift toward the Library of \$1.5 million from the Rockefeller Foundation. These capital gifts established a most helpful precedent.

Meanwhile, Dean Berry and General Cutler were also hard at work preparing the first case statements. No one who has not worked on such an undertaking can realize its travail. To speak for a single institution without offending someone is difficult; to speak for nine—a school and eight hospitals—is frightening. In the spring of 1958, the first formal case statement was printed: *The Library—At the Heart of the Harvard Medical Center*. About a year later, this was followed by *Better Health in the Years Ahead—A Plan to Assure the Nation's Primary Medical Resource*. The limited initial distribution was well received, and these two documents were to remain convincing sources of data for those with a sophisticated understanding of medical education.

During all this period, the Trustees of the Harvard Medical Center kept a weather eye on the progress of the Program for Harvard College with understandable impatience, for as month followed month, this massive national effort seemed to the Trustees to be impeding their progress. About 20 percent of the Alumni of the Medical School were also Alumni of the College. They worked for and gave generously to it. Any thought of conducting a campaign among the Medical School Alumni without a decent interval of time was unthinkable. In addition, if a University-oriented effort were to be launched, the Trustees must turn for leadership to the Harvard family. For the most part, they were exhausted by three years of devoted service to the College and had already made their "once-in-a-lifetime" gift to the

University. They had a right to ask for immunity, and the Center had a duty to respect this.

It was with great relief that the Trustees heard on November 18, 1958, a report from the Dean of a meeting the day before with Mr. Pusey. The Harvard Medical Center, he stated, would be able to plan, organize and execute a fund-raising program the following summer. While a few restrictions were to remain in approaching key prospects still reserved for the College, the Harvard Medical Center would be free to move ahead, assuming the "spotlight on the University stage."

In the summer of 1959, the writer's duties as Director of Public Relations for the College Program were drawing to an end, and my first contact with the Harvard Medical Center occurred when Dean Berry invited me to become special consultant to him—later I was to be appointed Assistant to the President of the Harvard Medical Center. By October 1, 1959, my preliminary plan was approved in principle by the Trustees of the Center. In outline, it made the following proposals:

1. The Center was to establish as soon as possible a National Committee. To broaden the appeal, small committees were to be formed in key areas throughout the country—they were later to become known as Friends of Harvard Medicine Committees—and were to be composed of both lay and Harvard Medical School Alumni leaders. An office was to be opened in New York, the money-capital of the country and always the largest source of support for Harvard in the past.
2. Since the College Program had demonstrated the effectiveness of a small, top-level committee that kept in constant review the prospects for larger gifts, it was proposed that an Executive Committee be formed and again that a special effort should be made to enlist talent from the New York area.
3. Professional fund-raising counsel was to be employed, initially to make a survey, and possibly to continue for a longer term.
4. Main reliance for professional guidance, however, was to be placed on a staff with headquarters at the Medical School. The School and Hospitals were to contribute to the fund-raising budget.

The findings of the survey conducted by professional counsel were helpful in confirming the decision to move ahead.

The report noted:

... the Medical School's alumni have an abiding loyalty to their School and take a lively interest in its welfare Currently, they have strong loyalties to their local institutions, which in many instances would interfere with major participation by them in fund-raising efforts of great magnitude Some help can also be expected from the alumni of Harvard College, although the Harvard Program has been completed too recently to justify large-scale participation.

The president of the fund-raising concern was to consult with the leaders of the Program from time to time for about a year, after which the arrangement was terminated by mutual agreement. Our counsel stated quite frankly that since the Program for Harvard Medicine was unique in the experience of his company, he had no useful precedents to guide him in helping us.

One last step remained before the final major phase could get under way. On May 10, 1960, the Board of Overseers and its Committee to Visit the Medical School and the School of Dental Medicine met in the Faculty Room to hear a detailed presentation of the long-range plans of the School. With their blessing, the Program was ready to move ahead.

FINAL PHASE THE PROGRAM FOR HARVARD MEDICINE

One would find it difficult to specify the exact moment when the Harvard Medical Center Fund ended and the Program for Harvard Medicine began. Indeed, it was merely a matter of semantics. To many, the original name was confusing, suggesting a geographical entity like many a medical center found in cities and towns throughout the country. The decision to change its name happened to coincide with the effort to broaden the fund-raising base and with the decision of Mr. Rand to resign as General Chairman—from the beginning he had set a time limit on the duration of his assignment.

If any exact date were to be chosen for the changeover, however, it should be October 11, 1960, the day when Mr. Ridley Watts, a member of the Harvard College Class of 1923, agreed to accept the complex challenges of General Chairman. Outspoken, generous almost to a fault, direct in his approach and totally without pretense, he was to give his full time, over a period of nearly five years, in

a devoted effort to bring new strength to his University and its Associated Teaching Hospitals. In the long history of capital campaigns it is hard to find more singleminded devotion.

Mr. Watts' appointment resulted from a remarkable stroke of good fortune. During the summer, Mr. R. Keith Kane, member of the Harvard Corporation, had invited groups of College Alumni, selected for their qualities of leadership, to a series of lunches at which Dean Berry presented the case informally. These affairs were helpful in refining his presentation, and enlisting allies for the campaign. They also yielded an unexpected dividend. One of those who had attended a luncheon met Mr. Watts on a ranch in Wyoming. One evening while sitting before a camp fire, he gave Mr. Watts a glowing account of what he had heard. Mr. Watts' interest was aroused and reported to the Dean, after which his capitulation was inevitable.

With the appointment of Mr. Watts in October, the work of organization proceeded apace. National and Executive Committees were appointed, and Friends of Harvard Medicine Committees enlisted in ten areas. All these committees were to work under a difficult handicap. Despite incessant attempts, it was never possible to present to these committees short, solid lists of prospects, at least half of whom might be expected to respond generously to a personal appeal. The College had raised 66 percent of its total from Alumni. Support of such magnitude could not be expected from the Medical School Alumni who were comparatively few in number; moreover, 20 percent of them had been involved in the College Program. The committees of the Program for Harvard Medicine had to turn, therefore, to non-alumni, and to foundations and corporations, most of whom were already heavily committed to local institutions. Securing gifts from these sources turned out to be a painfully slow process, requiring unusual skill in presenting the case. The refusal rate inevitably ran high. Solicitation by mail, unsupported by a personal call, never, so far as I can recall, raised a substantial gift, despite a number of experimental efforts.

Yet, these committees contributed importantly to the success of the campaign's progress, especially as a more sophisticated understanding of their function evolved with experience. Individually, their members opened doors to persuasive presentations by Mr.

Pusey, Dean Berry, Ridley Watts, the Faculty and others, leading to many a magnificent gift. Among those deserving special mention were Russel H. Patterson and Claude Forkner (about whom more later), Alumni of the School; A. Clifford Barger and Maxwell Finland, Alumni of the School and also members of the Faculty; Paul C. Cabot, Treasurer and member of the Harvard Corporation; Courtlandt S. Gross and John L. Loeb, past or present members of the Board of Overseers; George G. Walker, member of the Committee to Visit the Harvard Medical School; and Donald F. Bush and Walter S. Franklin, Alumni of the College. There were many more.

As in all large capital campaigns, success depended on large gifts, and 70.7% of the amount raised came in gifts, pledges and bequests of \$500,000 or more. No formula could ever be devised to cover all the strategies followed in securing these gifts. The individual files, often three to six inches thick, reveal that each was a campaign in itself, calling for ingenuity and adaptability. But each "campaign" contained within it four basic principles.

The first and most important step was to find among the Harvard family, a strong personal relationship to engineer the initial approach. Dean Berry, Mr. Watts and a few others were from time to time able to prove the exception to this rule, but in general, until a point of personal contact was established, no further effort proved fruitful.

The way had to be opened for a personal approach by an "expert witness"—someone thoroughly versed in the objectives of the School and the Associated Teaching Hospitals. More often than not, this led to a series of meetings, with Dean Berry or Mr. Pusey delivering the *coup de grace*. The purpose of all the preliminary visits was not just to tell but also to listen, for a favorable response was always dependent on an understanding of the aims and interests of the donor.

After each visit prompt and gracious followup by mail helped to drive home the points made, to establish personal rapport, and to keep the appeal alive.

Finally, at the propitious moment, a written request for a specific amount and purpose was prepared and presented, preferably again in person. These presentations were also carefully tailored to the circumstances.

Most effective use of the "expert witness" was achieved when prospects for substantial gifts, whether individuals or

officers of foundations or corporations, could be lured for a visit to the Harvard Medical School for a day or two. Here they gained acquaintance with the faculty, hearing their impressive accounts of research activities and new developments in patient care. Never did a visitor leave without being profoundly impressed, and the response in financial support was encouraging.

In the early years of the Program, these visitations to the School were organized in small groups. Four special "Dean's Days" were arranged over a period of two years. Attendance ranged from 35 to 75, although only a minority of the visitors could be considered bona fide prospects for substantial gifts. Inevitably, it seemed that the two or three Very Important Personages whom we were most eager to impress found the date selected for the meeting inconvenient. It was also found to be difficult for members of the Faculty simultaneously to make their presentations understandable to the uninformed layman in the audience as well as interesting to the scholars.

For the next three years, therefore, invitations were issued one at a time to the few individuals in the best position to help the School. We were thus enabled to "roll out the red carpet" in a way that seemed highly complimentary to our visitors. Members of the Faculty demonstrated again and again their amazing agility in adapting their material to the grasp of their listeners. While the load on Faculty and Program staff was increased by this change, the results more than justified the additional burden and gave an enormous lift to the program.

THE APPROACH TO FOUNDATIONS

During the course of the Program, \$20,667,269 was received in grants from 65 foundations, a record that few capital campaigns have equaled. Three brief anecdotes will illustrate the interest and variety of our discussions with the officers and trustees. In two instances, fictitious names have been used to safeguard anonymity.

The XYZ Foundation provided an encouraging "break" early in the Program. A committee member in a midwestern city approached the foundation confidently expecting failure. Grants were confined by a forbidding restriction in the charter to institutions in the local area. In approaching a sympathetic

board of trustees, the committee member was able to present a list of 53 Alumni of the Harvard Medical School, all of whom were currently on the faculty of the local medical school, many in lofty roles. The trustees decided that the Harvard Medical School was directly contributing to the health and welfare of the city just as truly as though the School were located down the street. Mr. Watts promptly reported their generous decision to his area chairmen throughout the country, stimulating additional grants from locally oriented foundations in the months ahead.

A small Boston foundation, the Elsie T. Friedman Charitable Foundation, had been using its modest income to make a number of small grants to local hospitals and charities. In early talks, Dean Berry and General Cutler gained the impression that the trustees were becoming disenchanted with this plan and wanted to make one gift that would contribute to better health in a more noteworthy way. Yet, the trustees felt they could not cut off their many small grants entirely. How could all this be accomplished? A perfect solution was found—to create a professorship on the installment plan. The idea was appealing because the professorship could be established immediately by pledging gifts for current support of the chair while additional payments built up the endowment over a period of years. The pleasure of the trustees can be measured by this excerpt from a letter announcing their favorable decision:

Harvard Medical School is the Nation's primary source of learning, of advanced research and inspirational teaching in medicine. By the establishment of this Professorship we hope to create an enduring source of benefits for all mankind. We can conceive of no use of Miss Elsie T. Friedman's monies which promises to generate so great a blessing to humanity . . . or which can be of greater honor to her memory. Also, we dare hope that our example may be a source of inspiration for others to do likewise, even those whose resources are not extensive.

Their wish was to be fulfilled. With many variations, "professorships on the installment plan" contributed to the establishment of half the twenty-six chairs created under the Program.

One further example may be of interest—the account must be oversimplified, for the negotiations continued over a period of more than two years, during which Dean Berry and Mr. Watts brought to bear their persuasive powers with individual trustees from Maine to Cali-

fornia. The lead to the ABC Foundation was supplied by an alert member of the Faculty who over a period of years had received from the Foundation a series of small grants for the current support of his department. Three questions occurred to him. First, if he had directed the same requests for grants to the NIH, would he have received favorable action? Second, was the Foundation supporting projects at other medical schools for which government grants were readily available? Third, if so, could not Harvard assist the Foundation in finding a more creative role?

It was an easy matter to match the Foundation's grants as reported in its annual statement against grants made for similar or identical purposes by the NIH. The analysis revealed that 54 percent of the Foundation's annual income was being utilized in this manner. Dean Berry was careful to point out the obvious fact that these grants were serving a useful purpose and suggested a gradual rather than a sudden shift in policy. After a careful study, the trustees voted to adopt a new pioneering role. Three other leading medical centers shared with Harvard the benefits of this decision.

CORPORATIONS

Early estimates of amounts that might be contributed by corporations because of their growing interest in philanthropy ranged from \$500,000 to \$3.5 million. The wide variation in expectations was due to uncertainty as to the extent to which we might overcome the reluctance of corporation executives to contribute to endowment. Although capital in education is as essential as in business, the uses to which it is put are very different. Moreover, no graduate school had ever come to corporations with such an ambitious program. Success in bridging these gaps in understanding was among the important achievements of the Program. As of December 31, 1965, sixty-eight corporations contributed in gifts and pledges \$2,783,179.

This notable accomplishment was made possible when Mr. Thayer Cummings, a member of the Harvard College Class of 1926, joined Mr. Watts in the spring of 1963 as Vice Chairman and a full-time volunteer. Although his activities were not limited to corporations, he was to assume a role of leadership in support of Mr. John J. Toohy, College Class of 1921, the Corporations Chairman. Mr. Cummings' creative bent, energy,

persuasiveness, and systematic followup kept this phase of the activity constantly moving ahead. In his 1965 Commencement address, Mr. Pusey referred to Mr. Cummings' devoted service as being "in our best ancient tradition."

Two incidents deserve special mention. First, the magnificent gift of \$500,000 from the New England Mutual Life Insurance Company. The Program was unusually fortunate in dealing with executives of broad vision and a willingness to investigate the facts with care—especially its President, Mr. O. Kelley Anderson, and its Vice President, Mr. Sherwin C. Badger. The decision of these two that the Company should make its own independent study of the contributions of medical education to life insurance in general and New England Life in particular was an act of business statesmanship.

Pointing out that they considered their contribution an investment from which they would receive important returns, Mr. Badger wrote,

Why should the New England Life not be the first to show a grasp of the potentialities of medicine by giving a substantial contribution to perhaps the boldest and largest private financial effort in support of a medical faculty ever attempted in this country? Our grant would be a true breakthrough in the responsibility of our industry to a field that is the lifeblood of the life insurance business. And our gift would be more than a token contribution; it would be large enough to indicate dramatically and convincingly that we are entirely serious in our purpose and objectives.

Another notable success was the heartening participation of the pharmaceutical industry. Eleven companies contributed a total of \$1,211,100 in gifts—more than half was contributed by a single company. Although many of these splendid gifts were the result of the combined efforts of many people, the close teamwork of Dr. Maxwell Finland and Dean Berry supplied the major artillery. Dr. Finland's efforts have not only brought new strength to the Thorndike Memorial Laboratory but also to the Harvard medical, surgical and neurological units at the Boston City Hospital while making a promising start in acquiring resources to support clinical pharmacology.

THE ALUMNI ROLE

From beginning to end of the Program for Harvard Medicine, Alumni in growing numbers accepted posts of leadership. Eleven of them served on the National

SOURCE OF GIFTS

RESULTS OF A PROGRAM FOR HARVARD MEDICINE

Category	Total No. in Category	FOUNDATIONS		INDIVIDUALS		CORPORATIONS	
		Amount	No.	Amount	No.	Amount	No.
\$1,000,000+	17	\$14,900,000.00	8	\$17,495,028.47	9		
500,000+	11	3,065,000.00	6	2,200,000.00	4	\$500,250.00	1
100,000+	43	2,028,421.00	9	4,242,411.71	23	1,635,000.00	11
50,000+	20	210,410.46	4	730,462.14	11	250,150.00	5
25,000+	34	260,000.00	10	505,564.43	16	225,050.00	8
10,000+	83	161,587.78	10	816,759.23	62	123,300.00	11
Under \$10,000	4,428	41,850.00	18	2,425,347.55	4,378	49,429.25	32
Special Funds				*2,053,980.68			
Totals	4,636	\$20,667,269.24	65	\$30,469,554.21	4,503	\$2,783,179.25	68

*Blumgart, Meigs Funds and amounts originally received as gifts to Associated Teaching Hospitals

Committee. The minutes of the Harvard Medical Center had noted, "The Medical School Alumni provide a solid core of 'agents' who could with lay support bring 'great added strength to the undertaking.'" It will never be possible to estimate in dollars exactly how much the Alumni contributed to the overall success of the Program. But the amount was very large indeed.

The real test of their devotion to the School came in the last three years of the campaign. Under the leadership of Dr. Thomas Lanman, followed by Dr. Langdon Parsons, they had already established a record in annual giving unexcelled in the University for participation, and had achieved national recognition on many occasions. Throughout the Program their high performance in annual giving continued without abatement.

In November, 1962, Claude E. Forkner, HMS '26, was appointed National Alumni Chairman of the Program. By December 31, 1965, he could announce an extraordinary result: In pledges, gifts and bequests, 3,247 Alumni and their families had contributed \$4,099,121, exceeding their high goal by \$600,000 and establishing a record for participation and generosity unsurpassed so far as can be determined by any other medical school in the country.

For his part in leading this magnificent effort in which more than 750 Alumni served on some 136 committees through-

out the country, Dr. Forkner received on Alumni Day 1965 a gold medal and citation, reading in part, "With imagination, energy and consummate skill, he has been spokesman and interpreter for Harvard Medicine, carrying its message throughout the nation and stimulating new understanding and support for its objectives. By the example he has set as a physician, teacher and loyal Alumnus, Dr. Forkner has won the lasting thanks of his fellow Alumni and his Medical School."

One statistic will make clear why it is unfortunately impossible to single out individual Alumni for special mention—136 of them gave not only untold hours as area chairmen, but also contributed as a group more than a quarter of a million dollars.

Meetings, generally considered an essential ingredient of a capital campaign, were not the strong point of the Alumni effort—naturally the care of patients had to come first. There were two exceptions, however. A team led by Mr. Pusey and Dean Berry, supplemented by Alumni and members of the Faculty, toured the country early in the campaign to acquaint groups of Alumni with the progress, developments and new objectives of the School. The purpose of these meetings which were well attended was not to seek money but to create understanding. Dean Berry who bore the brunt of the effort was at his eloquent best in ex-

pounding his convictions about trends in medical education.

Another successful venture was the National Telephone Report broadcast on April 30, 1964. Fourteen cities participated in this two-way broadcast with Boston acting as the host city. Remarks by the President, the Dean and the National Alumni Chairman were followed by progress reports from 14 cities. To those attending, the voices of old friends and associates speaking from coast to coast created an atmosphere of happy nostalgia and a sense of national unity in support of their School. The fund-raising objective of creating a deadline at the halfway mark was also met, stimulating a sense of urgency to finish the job.

Providing adequate staff support to service Alumni committees was made unusually difficult by dint of the relatively small size of the Alumni body—about 6,000—and the fact that it was thinly spread over three million square miles of territory. Five field directors were appointed, located in California, Chicago, Washington, New York and Boston. Even by doubling the number of areas generally accepted as the upper limit for a field director to service, nearly half the Alumni living in the smaller cities and towns were left uncovered. A plan rarely used in capital campaigns turned out to be an ideal solution.

Depending entirely on telephone calls

and letters, a carefully planned program made it possible to organize and service 88 additional areas where 2,000 Alumni live. One staff member, later augmented by a secretary, was responsible for the entire operation. Alumni in these areas were to contribute more than a half million dollars. The friendly voice of Mrs. Barbara Kislak was gracefully accepted by the area chairmen as representing by extension the authority and prestige of both the Alumni Chairman and the Dean.

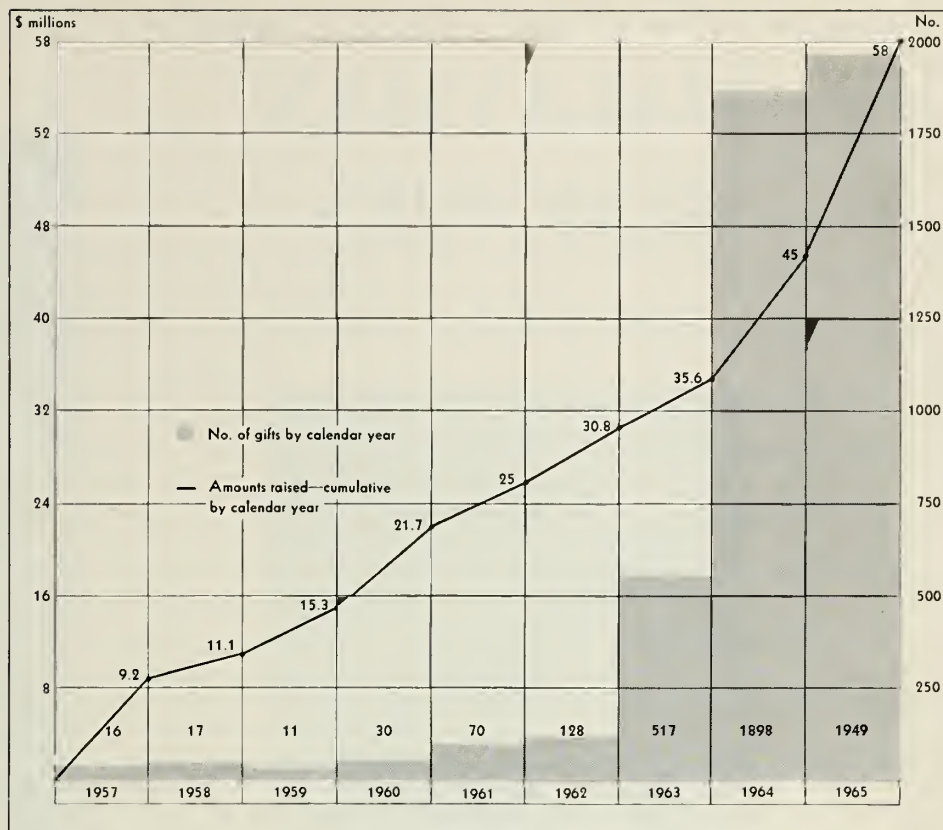
THE SPECIAL FUNDS

As noted earlier, a vexing problem of the campaign was the identification of prospects who had both the resources and the motivation to support the Program. This dilemma led to the acceptance of a policy which violated one of the revered rules of fund raising: "Be firm," so the rule book states, "in outlawing campaigns within campaigns. They will encourage token gifts and divert volunteers and staff alike from the main purpose—seeking substantial and unrestricted gifts."

From the viewpoint of the Program for Harvard Medicine, however, named funds had a unique virtue. By their nature, they offered a built-in means of finding prospects and the best approach to them. The plan of organization was of necessity uncomplicated. Generally, small committees were formed by those with strong personal interest in the project. The Program staff was available to write booklets and letters, to arrange for printing, and to handle the gift accounting.

Among the chairs created in this way were the Paul C. Cabot, Ridley Watts, Joe Vincent Meigs, Herrman Ludwig Blumgart, Elliott Carr Cutler and James L. Gamble Professorships. Other special funds that attracted widespread support were the George Packer Berry Fund and the sponsorship by the Aesculapian Club of a leisure reading room in the Countway Library.

If Alumni occasionally felt they were being unfairly subjected to a multiplicity of appeals, they were also among the most enthusiastic in working and giving to commemorate the names of beloved teachers, famed scientists and lay leaders who have done so much for the School. The added effort was richly repaid in both a material and intangible way—it is estimated that approximately \$5 million was raised in this manner.



THE STAFF

The campaign of necessity had to be conducted on a retail rather than a wholesale basis. This placed unusual demands on its staff. They rose superbly to the challenge.

Deserving special mention are Bayley F. Mason, Assistant Manager and Public Relations Director of the Program, now Assistant to the Dean for Resources; David O. Smith, Field Manager and Director of the Alumni Campaign; Dudley M. Todd, Field Director for the New England Area. There were many others but one name certainly cannot be omitted—that of James R. Reynolds, Assistant to President Pusey. This friend, wise counselor, respected and beloved throughout the University, never failed to respond to a call for help.

CONCLUSION

Of a University more than any of man's institutions it may be said that excellence must be rewon in each succeeding generation. In its acceptance of the inevitability of change and the constant renewal of its scholarly pursuits in concert with the needs of an evolving civilization, Harvard has been unusually fortunate. Let it not be forgotten, however, that each new forward thrust of scholar, teacher and student has been fostered by concerned men who provided laboratories, classrooms, libraries,

books and the resources to guarantee the freedom to explore. Harvard has also been fortunate in its "aristocracy of those who care."

Through the Program for Harvard Medicine, many have joined this noble company in the finest tradition of the University. If the means and the methods did not always follow the course conceived by Mr. Conant and his Standing Committee, the new federation of School and Teaching Hospitals has successfully launched and brought to its conclusion a Program from which all will benefit and on which a more secure future may now be built.

And yet the end is not in sight and never can be. "It is provided in the essence of things," wrote Walt Whitman, "that from any fruition of success, no matter what, shall come forth something to make a greater struggle necessary." Change is again in the wind and opportunities to move ahead under a vigorous new Dean lie all around us. "Closer integration and cooperation" of the Harvard Medical School and the Associated Teaching Hospitals will again be put to the test. And so, in closing the book on the Program for Harvard Medicine, it seems appropriate to add to the thanks for a job well done, a "goodspeed" to those who will take up the task in the years to come.

Re: MALAYSIAN MEMORIES

by John S. Robey '51



Alice surveying the jungle from a hunting lookout. (Left) The hospital's grass cutter. (Below) An aborigine child more interested in a cigar than in me.



February, 1966

Dear Uncle Jack,

Alice and I want to thank you for having made possible our most fascinating and rewarding trip to Malaysia last summer.

I thought you might find it interesting if I outlined our experiences for you. We flew from New York to Athens where we stayed briefly. Then on to New Delhi where my good friend and medical school classmate, Professor Madan Singh '51 entertained us lavishly. He is in charge of the cardiovascular laboratory at New Delhi's Irwin Hospital. He cared for Nehru during his long illness and was Shastri's attending physician. The best and the appalling worst of modern India was shown to us in a way that we could never have seen as ordinary tourists. India with its seemingly insoluble dilemma of incredible overpopulation, underproductivity and poverty was in startling contrast to Malaysia. Although poverty is great in this newly established nation, there is no starvation. Despite the current "confrontation" with Indonesia, there is widespread optimism and a healthy pride in the nation without the chauvinism one associates with newly emerging countries.

Physically, the Malay peninsula is beautiful as you know from your ornithological expeditions. It is still 80 per cent virgin tropical jungle and abounds with wild life. We had many opportunities for birding and saw such remarkable fowl as rhinoceros hornbills, racquet-tailed drongos, sibilas, bulbuls, forktails, sunbirds, flower peckers, bee-eaters, tit babblers, munias and many more. Here surely is an ornithologist's paradise. The great monitor lizards, flying lizards, cobras, vipers and other such reptiles are frequently seen. Monkeys cavorted daily on our lawn and occasionally stole into the house; gibbons were heard howling eerily in the jungle; but tigers, tapirs, saladangs, and elephants were harder to see because they remain in the more remote jungle.

Kuala Lipis, the town in which we lived, is a small jungle community of 3,000 serving another 30,000 kampong or small village dwellers and rubber plantation workers. The three main ethnic groups--Chinese, Indian and Malays--still retain their own cultural traits to a large extent with little intermarriage. There is a fourth group, the aborigines, who are intriguingly primitive forest nomads.

The district hospital to which we were assigned has about 170 beds and is a rather disparate collection of buildings of varying antiquity. Goats and chickens stroll about and ward cats clean themselves on patients' beds. The whole scene reminded us of Schweitzer's institution in Lambaréné.

The wards, though barren, are bright and roomy; relatives, visitors and the merely curious wander in and out freely. The indigent pay nothing, third class patients 10 cents a day and first class patients, 30 cents a day.

The medical staff of the hospital varies from month to month. There are transferees, new arrivals and short term personnel such as myself. When we were there, the staff consisted of only two physicians: one was an able young internist from Brooklyn; the other was a Malaysian physician who was reasonably well trained but who did not seem very interested in his work. The senior

staff nurses, in addition to their nursing duties, helped to maintain a school for the training of practical nurses.

One of Malaysia's greatest deficiencies is the lack of educational facilities beyond the secondary level. Too few individuals are qualified for training in the many fields necessary for national progress. This situation was very apparent in Kuala Lipis.

Our patients presented a wide variety of disorders, some of which are familiar in the U.S., though many indeed are rare. Wounds, either trivial or major, tend to become grievously infected, and are a common problem. They progress into festering ulcers or abscesses and generally require hospital treatment.

Fractures are frequent and severe. When fractures are compound, osteomyelitis usually sets in and often, amputation is the only solution. Malaria in its severer forms is a frequent diagnosis and usually requires hospital care. Yaws, the dread disease of the tropics has been almost entirely eliminated. Leptospirosis is seen often and is always a diagnostic challenge. Parasitic infestations, in one form or another, are almost universal. The possibility of these infestations was routinely considered, whether or not the patient had another disease. Tuberculosis is, of course, endemic and many of the hospital beds are filled with cases essentially incurable despite the availability of the new antimicrobials. Surgery of the extensive sort required for these advanced cases can be done in only a selected few due to a pathetic lack of facilities.

My contribution as a visiting pediatrician is difficult to define. As a new person on the scene, I offered my different views and solutions to the many problems. I, in turn, learned a great deal from daily rounds, although I often found myself in situations far beyond the scope of pediatrics.

There was no surgeon at this time so the team captain and I did any necessary surgery. This included emergency and minor operations such as appendectomies, removal of bladder stones, suturing of lacerations and the opening of innumerable abscesses.

I managed the pediatric in-patients and the large out-patient population. Hospitalized children generally suffered from some form of malnutrition, diarrhea and dehydration, skin infections, malaria or anemia of diverse etiologies. These were in addition to the problems of rheumatic and congenital heart disease, tuberculosis or pneumonia encountered in any general hospital. I also taught them some new concepts of fluid therapy and other pediatric techniques.

Every morning the corridors of the hospital were filled with many waiting people; turbaned sikhs, Malays in sarongs, Chinese with infants tied to their backs and many others in more non-descript clothing. I conducted my clinic in a room that had a single light bulb and a slowly rotating ceiling fan. My interpreter, a dark Indian nurse, spoke English and the three local languages. She was quietly tolerant of my "whole patient" approach to some of the problems.

Despite her ability to translate, I found the language barrier similar to the type of problems encountered by a veterinarian. A multitude of disease entities might all present with the same complaint—"fever," "abdominal pain," "giddiness," "chills." Brief physical examinations had to suffice and diagnoses were made while people peered through windows and doors. All patients had to be treated with some medication or they would persevere

until so gratified. It was fortunate that their level of medical sophistication was such that they could not distinguish between antibiotics and aspirin. Errors were inevitable with a burden of 150 to 200 out-patients a day. If one missed a diagnosis one day, the patient, having no other medical facility to turn to, hopefully would return another day. In some cases, however, valuable time would be lost in starting treatment.

We saw a special group of Malaysians, the Aborigines (or *abos* as they are generally called), in their native surroundings. They are jungle nomads who still live in a stone age culture. Alice and I with Felix, our guide, friend and interpreter, passed one of their ephemeral villages and we were welcomed by these shy, giggling, child-like people who allowed us to take as many pictures as we wished.

All the villagers had immensely enlarged spleens from chronic malaria but they seemed to tolerate it well. Several however, were lying ill in their rattan roofed lean-tos and clinically appeared to have acute malaria which we treated. Sadly, no medical care is available to these people nearer than 75 miles away by river. They seem to accept sickness and death as part of their lives. The treatment we gave will be of little long term value for without some understanding on their part of rudimentary sanitation procedures and the meaning of illness and of treatment, no long lasting benefit can be gained. The Malaysian government is now developing health centers and educational programs for the aborigines and it appears that good progress is being made.

Alice, in addition to helping me in the clinic, conducted a survey to determine why people came to the hospital, what we could and could not do for them and the social circumstances under which they lived. She had several conferences with the local welfare worker who was anxious to learn about social welfare problems in the United States and how we solved them.

Our life in Malaysia was not all work. In the evenings, that civilized beverage, gin and tonic, (alas, no Schweppes) was served and exotic dinners of variously edible foods such as squid, monkey, wild boar and buffalo were prepared by our houseman. The jungle trips and evening forays to hunt civet cats and flying foxes were a constant source of excitement. The flying foxes are found only in Southeast Asia and have a wing spread of four feet. A four foot target might seem easy to hit but with the jungle darkness and the erratic flying habit of bats, we were not often successful.

This expedition was certainly of value both to the Malaysians and to the Robeys. It opened our eyes to new aspects of the world and changed our perspectives at home. CARE/MEDICO seemed very appreciative of our efforts and we, in turn, are more grateful than we can say for your help in making our trip to Malaysia possible.

Affectionately,

Jock

*“The dilemma of modern medicine is that its unwieldy organization impedes its effective application... Organization of its services has lagged behind its scientific progress... Federal, state, and local governments have developed a series of largely unrelated health services to meet the special problems or needs of particular groups. These governmental agencies should assume the responsibility for pulling together the diverse element.”**

MEDICAL CARE

Financed by Government in California

by Allan M. Butler '26

Dr. Butler is professor of pediatrics, emeritus. At present he is a lecturer at Stanford University Medical School and director of medical education at St. Luke's Hospital in San Francisco.

The Story of Constructive Action Toward Comprehensive Insurance For All

In January 1961, the Report of the State Department of Social Welfare on California's Public Assistance Medical Care Programs¹ described the fragmentation of California's tax supported medical services and the resulting limitations on their effectiveness and economy. Ten federal or state agencies and fifty-eight counties administered some 20 categories of health and medical care.

Six months later the State Assembly, with the Senate concurring, resolved "that the State Department of Public Health is hereby requested to collect and analyze data necessary for the development of standards in governmental health services, appraise continually the quality of care provided and periodically report its findings to the public."

Thus it was in November 1961 that I was asked to be chairman of a Task Force on Public Medical Care for Children in California. As acquisition of competent chiefs of services at the Detroit Metropolitan Hospital made my position of director of clinical services superfluous, I went to Berkeley, California in February of 1962.

The Task Force was composed of 10 members of the Bureau of Maternal and Child Health, 3 social workers of the department, 26 practicing physicians, 8 registered nurses and an advisory committee of 15 physicians, one county supervisor, a representative of the Department of Education, of the Department of Social Welfare, and of the University of California's School of Nursing in San Francisco.

The study of maternity and pediatric care in California's County Hospitals began in April 1962, and was completed in July 1964.

As the study progressed, its findings were presented in 1963 to the Northern California Public Health Association and the Association of County Supervisors. A summary of the Task Force's final report was presented at the annual meeting of the California Medical Association in April 1965. Excerpts from that summary are as follows:²

That the county hospitals provide needed maternity and pediatric services to about 15 percent of the population of California is beyond question. Indeed, in eight counties, the county hospital is the only hospital in the area and serves all patients regardless of their economic status. However, the quality, economy and availability of services vary greatly. A few county hospitals have excellent facilities and adequate staffs, provide good medical care, are sincerely concerned with the social rehabilitation of the patients they serve, and perform an essential role in the education and training of physicians, nurses, social workers and technologists. However, the county hospital "system" exemplifies the lag in institutional adaptation behind advancing scientific knowledge and changing social circumstances that is a primary deterrent to more effective, available and economical medical care in the United States.

Present county hospital laws and policies result in: (1) a segregation of hospital facilities resulting in uneconomical multiplication and inflexible utilization of facilities and personnel and thus a deterrent to desirable regional hospital planning; and (2) a fragmentation of patient care, incompatible with effective continuity and economy of care. Thus, the county hospital serving only the medically indigent is not providing the quality, scope, flexibility and economy of services that should be provided. Despite recent advances in regional planning, our laws continue to permit the operation not only of segregated county hospitals for the care of medically indigent patients but also segregated federal hospitals for veterans and for military dependents, segregated state hospitals for the mentally ill and retarded and poorly coordinated non-profit community and proprietary hospitals for the care of other patients. This segregation and lack of coordination result in an extravagant inflexibility in use of beds to meet fluctuating needs.

EFFECTS OF SEGREGATION

In the larger densely populated metropolitan areas, this segregation of hospital facilities for tax-supported medical care tends to create a large central hospital whose "bigness" and centralization of facilities create problems of personal relationships and travel.

In the rural and mountain counties, this segregation adds to the difficulties of regional planning and encourages the establishment of hospitals inconsistent with desirable location, size, ownership, type of hospital and adequacy of staff and facilities. The fractionation of hospital facilities between non-profit community and church hospitals, county hospitals and proprietary profit hospitals results in maternity and pediatric units so small that provision of desirable physician and nursing care is unduly difficult and prohibitively expensive. Thus in many communities, in spite of the costly duplication of hospital facilities, there is no hospital adequately staffed and equipped to provide the benefits of modern medicine to rich or poor.

FRAGMENTATION

The medically indigent receive maternal and child health care from public health physicians, school health care from physicians designated by boards of education, office and home sick care from the physician chosen by the family, and county hospital care from county hospital physicians. This results in a fragmentation of care that is inefficient and uneconomical and that places severe burdens on conscientious physicians. Moreover, the free choice of physician for certain office and home sick care and the designation by government agencies of physicians who provide preventive health services and hospital care is a paradoxical inconsistency.

VARIATION IN QUALITY

In some county hospitals the medical and nursing staffs are competent and eager. Some have medical staffs that are inadequate in size and quality. Most suffer the shortage of nurses, particularly at night, that is common in hospitals throughout the United States. However, in spite of shortages and often low salaries and trying conditions, the majority of nurses are well motivated and struggling laudably to provide needed services.

In others, there is but little concern that "second-class" medicine is practiced with focus on an episodic need and little consideration of patients as persons.

* Governor's Committee on Medical Aid and Health: *Health Care for California*. California State Department Public Health, Berkeley, 1960.

1. Greenfield, *California's Public Assistance Medical Care Programs*, California State Department Social Welfare, Sacramento, 1961.

2. Butler, A. M. and Corsa L. Jr., *Maternity and Pediatric Care in County Hospitals in California*. Bureau of Maternal and Child Health, State Department Public Health, Berkeley, 1965.

Persistence of the concept that in-patient hospital treatment of episodic or chronic disease is the primary role of county hospitals limits realizing the potentialities of out-patient and out-of-hospital services in preventing illness and minimizing admission and readmission to hospital and length of in-hospital stay. Adequate integration of hospital in-patient and out-patient, public health clinic and home nursing care is spotty. While some hospitals provide exemplary physical rehabilitation during hospitalization, current inadequacies of out-patient and out-of-hospital care limit the effectiveness of care and the value obtained for dollar spent.

County hospitals provide general practice residency training that neither meets standards recommended by the Academy of General Practice nor places due emphasis on "family physician" rather than "general" practice. While some of the general practice staff members of county hospitals are excellent physicians, limiting their services to their fields of competence, some are not doing so.

PROFESSIONAL REMUNERATION

Whether doctors are remunerated by full-time or part-time salary, per session, per hour or per operation, the scale of remuneration by different hospitals varies considerably and often is inadequate for a desirable quality of service. Moreover, the tradition of physicians providing free service to patients whose care is financed by private charity when applied to patients whose care is financed by government results in an inequitable and hidden subsidy of government services by physicians.

ELIGIBILITY

Eligibility for county hospital care on the basis of county residency seriously inhibits patients receiving needed medical care and is paradoxical and impractical when hospital planning is based on hospital service areas or districts. In many county hospitals the administrative determination of economic eligibility being based on past monthly income with little consideration that the cost of needed care in other than the county hospital may pauperize the family. Similarly, current practices of property lien taking and waiving the statute of limitations may convert medical indigency to social indigency. Or the fear of such may so delay seeking needed care as to increase the ultimate cost. In addition, there is uncertainty that the collections thus exacted equal the costs of collection.

COSTS

Current accounting in many county hospitals is such that it is difficult to appraise efficiency or lack of efficiency and the value received for the dollar spent or to make valid comparisons with costs of similar services provided by other hospitals.

IMPLICATIONS FOR FUTURE

The findings of this Task Force support the growing consensus among physicians, laymen and government bodies that the present county hospital system is a deterrent to re-

gional planning and to development of economical and effective maternity and pediatric services for families eligible for tax-supported medical care. Thoughtful consideration and constructive action on the following seem warranted:

1. Gradual elimination of segregation of patient care on the basis of the patient's economic status by conversion of county hospitals to community general hospitals administered by boards of trustees appointed by the county supervisors, and by admission of patients to all qualified community general hospitals (including the converted county hospitals) with reimbursement from tax funds on a cost basis.
2. Development of optimally sized community general hospitals by public consideration of conformity to regional planning in regard to location, size, ownership, type of hospital, adequacy of staff and facilities and coordination with other health facilities and by opening non-profit community hospital staff membership to all licensed physicians, appropriate staff committees designating the type of professional services each staff member is qualified to perform.
3. Provision of effective and economical tax-supported medical care by prepayment of comprehensive medical services for families with children whose members are eligible for county hospital care from pooled available federal, state and local funds now financing various aspects of such care with such subvention as may be needed added from state and federal sources. The comprehensive services of such a prepayment plan should integrate well and sick care. It should include services of a family physician to assure desirable personal relationships and continuity of care; specialists to whom the family physician refers his patients when they need care best provided by qualified specialists; special clinics for diagnostic procedures and ambulatory care; hospitals with facilities appropriate for the provision of modern in-patient and out-patient hospital care; and home nursing care. Families should have free choice of any statewide, regional or local plan that will provide such services.
4. Adequate compensation of qualified physicians and other qualified health personnel for services to recipients of tax-supported care.
5. Designation of a state agency or council to establish standards of hospital and professional services qualifying for government reimbursement.
6. Elimination of county residency as a criterion of eligibility for tax-supported medical care by applying prepayment coverage statewide.
7. Institution of uniform cost accounting.

8. Improving the role of county hospitals in internship and residency training. The larger county hospitals are performing a role in the education and training of physicians, nurses, social workers, technologists and hospital administrators that is essential to the provision of needed professional personnel in California. However, county hospitals, in general, are failing to develop their exceptional potentialities for training the family physician, whose role in providing continuing health and personal medical care, diagnosis, ambulatory and home therapy and in referring his patient for specialist care becomes more essential to the economy and effectiveness of care as specialization increases.

Simultaneously with the County Hospital study, the Bureau of M.C.H. in studying Public Health Child Health Conferences in 643 locations found a segregation by economic status that contributed to fragmented, uncoordinated, and in many areas, substandard care of low income families. In January 1964, the California Medical Association Council Ad Hoc Committee to Study the Role of the County Hospital recommended that county hospitals be converted to general community hospitals. The California Medical Association approved this recommendation in April 1964.

Also of interest in relation to improving health and the quality of life is the following recommendation of the State Board of Public Health, made in January 1964:

It is recommended that local health departments provide appropriate services in the field of family planning, which may include:

1. Promotion of availability of program elements such as
 - a. Assembling knowledge about family planning, attitudes, values, and information held by population groups.
 - b. Public and professional educational services about the health benefits of family planning and fertility control methods.
 - c. Professional services for sterility correction, fertility control and genetic counseling for all segments of the population, making available methods acceptable to families of any religious persuasion.
 - d. Evaluation of the adequacy of the community's family planning efforts.
2. Provision of program elements which are not otherwise likely to be made available, including family planning services for those groups who cannot reasonably obtain them.

Reports of the Advisory Committee on Maternity and Pediatric Care in County Hospitals and on Child Health Conferences, based on Task Force findings, were made public by

the Department of Public Health in November 1964.

In compliance with the State Assembly resolution of 1961, the Health Department during 1963–64, undertook a study of the appraisal of quality of hospital services. An index was developed that permitted relative ranking of hospitals, with appropriate adjustment for variation in size. The index ratings of county hospitals agreed well with those of the site visiting teams of the Task Force. The better county hospitals rated as high as the better voluntary hospitals, but some rated lower than any of the private hospitals studied.

With this background, and the stage set for the expansion of government financed medical care by the passage of Federal Public Laws 88–452, 88–156, 89–97, and the older American Act, the California Legislature passed, and Governor Brown promptly signed Assembly Bill No. 5—The Casey Bill.

This bill, now law, provides through a system of prepaid health care, or contracts with carriers, for basic and extended health care to the extent practical “for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of such care would jeopardize the person or family’s future minimum self-maintenance and security. . . . The means employed shall be such as to allow eligible persons to secure basic health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability. . . . The board of supervisors of each county may prescribe rules which offer free choice of hospitals to those requiring hospital care . . . so that the county hospital and other hospitals in the community share in providing services to paying patients and to those who qualify for public medical care . . . Health care shall also be provided after January 1, 1967 . . . to any individual in the case of a catastrophic illness or accident, when the uninsured cost of care for such . . . exceeds 50 percent of the annual gross income of the individual or his immediate family.” This provision applies “only to those cases in which the federal government will participate financially in the assistance granted.

“No prescribed period of residence in this state shall be required as a condition of eligibility . . . No relative, other than the spouse shall be held to be financially responsible for the cost of basic care received by an adult . . . No relative, other than the parent or parents of a child under 21, shall be held to be responsible financially for the cost of health care or related sources received by such child.”

The services include inpatient, outpatient, laboratory and x-ray services, skilled nursing home services, physician services—whether furnished in the office, patient’s home, hospital, skilled nursing home or elsewhere, dental services, physical therapy and related services, and “other diagnostic, screening, preventive and rehabilitation services,” prescribed drugs, dentures, prosthetic devices and eye glasses prescribed by an ophthalmologist or by an optometrist.

The director of this program is the Administrator of a newly created Health and Welfare Agency, who will carry out the provisions of the Act with the advice of the Health Review and Program Council. The Council consists of 11 members appointed by the Governor, 5 of whom shall be members of the health profession. The Council shall “plan for the development of a comprehensive program of medical care for all medically indigent persons by 1975; promote the most efficient use of available health facilities; compare, in cooperation with professional associations, medical care given under this program with accepted standards for the purpose of reducing morbidity and mortality and improving the quality of care; and review the need for systematic grading of health insurance prepayment plans.

All federal and state funds for health care will be pooled in a state Health Care Deposit Fund. Expenditures of state and federal funds to meet the needs of people, not categorical disease, will be made upon the order of the Controllers in accordance with certifications made by the director.

But this legislation is only the beginning. The legislature is now considering the following challenging ten-year program called “Cal-Med” through which “every person should have equal opportunities for vital health services. The misfortune of bad health should not create an undue economic hardship for anybody. Every person should be free to select the physician, hospital and health insurance plan of his choice . . . the poor man should be able to receive his medical care in the same way and from the same professionals as the rich man . . . Health care funds are pooled (in the Health Care Deposit Fund) and certain amounts can be withdrawn by any citizen according to his medical needs and his financial position. The program recognizes no categories—only people. A single administrative system will be used to convert public health funds into citizen purchasing power for any kind of health services.”

All California families will automatically become eligible as they file a State Income Tax Return. Gross income, resources and size of family, as reported on the tax form will determine the proportion of benefits paid from

the Health Care Deposit Fund. It will also determine the portion to be paid by the family as their Participation Expense. The Participation Expense will include any contribution by unions, employers or fraternal organizations toward covering prepaid health benefits or insurance premiums. Welfare recipients, other low income families, and all other citizens will be in the same system. The only real difference will be in their Participation Expense. For those over 65 who participate in Federal Medicare, Cal-Med will be a supplement.

Hospitals will be reimbursed on the basis of cost, and physicians, according to the prevailing or usual charges of the locality in which they reside. County Hospitals will be permitted to bill patients and receive payments from Cal-Med and private carriers just as any other hospital. But to avoid fragmentation of medical services, County hospitals will be eligible for Cal-Med reimbursement only if they allow their patients to be attended by their personal physicians—if those physicians are professionally qualified for staff membership in the County Hospital.

Thus the laudable tradition of private charity medicine and of doctors giving free service will be virtually abolished. The medical care of the medically indigent will be financed by the systematic prepayments of some 80 percent of the population, instead of unsystematically by some 20 percent. Discrimination and segregation will end and free choice will be possible.

But how will this effect patient shopping around, the continuity and economy of care, and our current ward teaching services? Will free choice of physician have to be limited to choice of the front line or primary family physician? Will the choice of consultants or specialists be the prerogative of the family physician and not the patient? To promote continuity of care, by and through the family physician, remove the deterrance of fee-for-service to referrals, and lessen paper work, should the family physician be paid on a per capita basis? To lessen the pressure on the family physician, to improve economy and availability, should a family health and medical care team—composed of family physicians, visiting nurses and social workers supported by laboratory facilities replace the solo practitioner?

To increase economy, team work and the quality of specialist care, should specialists, other than family physicians and psychiatrists, be hospital or clinic based?

Such questions suggest that realization of the potentialities of improved financing and distribution of the costs of medical care resulting from expansion of third party payments may well require increasing consideration by physicians of the organization and sufficient delivery of medical care.

How to Deal with the Neurotic Patient



It is seldom wise to allow patients to enter the inner sanctum

Or, what every young doctor needs to know

by Gerald D. Klee '52



before waiting at least an hour.

EVERYONE knows that a lot of patients are neurotic or even psychotic. But not everyone knows what to do about it. Here are a few helpful suggestions for doctors early in their careers. The principles and methods described have been developed by experienced practitioners and have stood the test of time.

Any harassed physician can tell you that many patients who come to his office have emotional problems of one sort or another. In fact, many of them are suspected of making up aches and pains as an excuse to get into the office and talk about what is on their minds. Since a neurotic means time and trouble, it is important to recognize him as early as possible, preferably at the time he calls for an appointment. Some prudent practitioners believe that all patients should be warily regarded as potential neurotics.

The doctor-patient relationship is divided into natural phases which will be discussed in sequence.

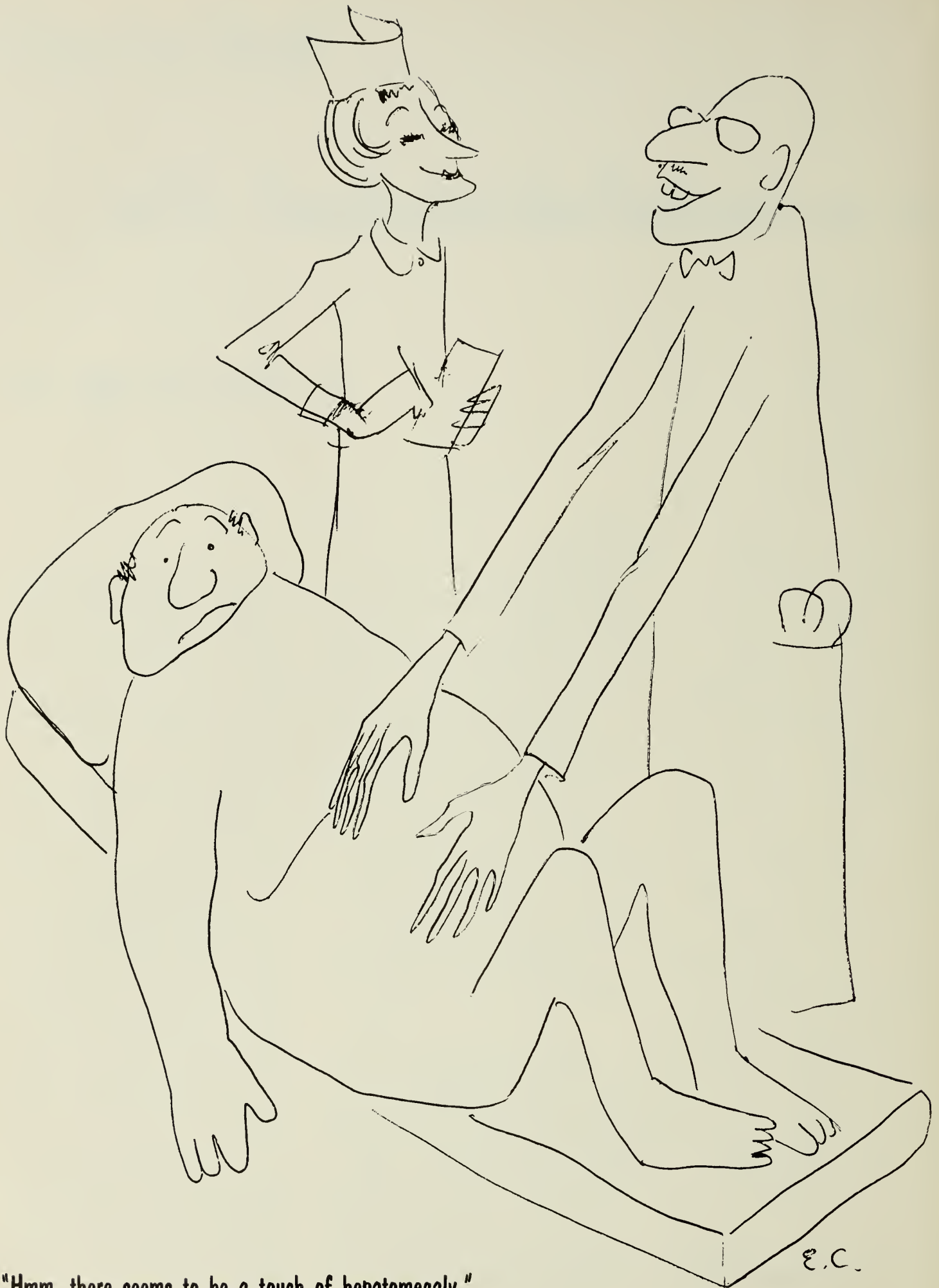
IF THE patient comes for an office visit, he will, of course, come to the waiting room. This is the first line of defense and merits the most careful management. Proper use of waiting room techniques can reduce considerably the burden of succeeding phases.

The first step of this technique is to postpone access to the waiting room for a period of, say, one to eight weeks. With few exceptions, it is an error to grant a patient an immediate office appointment. Only by making access difficult can a patient be impressed

by how sought after, busy and successful the doctor is. This tactic is not to be ignored, since the best medicine may be of little avail if the patient is not sufficiently impressed with the source from whence it comes. Early in one's career is the time when it is most essential to remember this and the following precepts. When referrals are few and time hangs on your hands, do not, in your distress, forget them.

When the patient finally arrives in your waiting room, there are certain procedures to be followed. Bearing in mind that a cooling off period reduces or even causes the disappearance of many complaints, it is seldom wise to allow a patient to enter the inner sanctum before a wait of at least an hour. This can be arranged easily by giving multiple appointments for the same time. Even if you have just opened an office and have only five patients, schedule them all for the same time. A simple bookkeeping technique which is also useful, is that of writing two o'clock on the patient's appointment slip, but three o'clock for the same appointment in your book. Most receptionists learn this technique very readily and can usually develop their own ingenious variations.

The side effect of these methods, and one that provides additional advantages, is a crowded waiting room. It is axiomatic that the patient should enter the examining room with the proper attitude. This should be a blending of awe, trust, fear and reverence. These attitudes can best be instilled by non-verbal techniques of communication. Few things



"Hmm, there seems to be a touch of hepatomegaly."

have been discovered more effective for this purpose than the experience of sitting with one's troubles for one to two hours amidst a horde of similar sufferers.

The effect is further heightened by a nurse or receptionist who has learned to behave like a priestess guarding a holy shrine. (Unfortunately, most receptionists are incapable of learning this difficult art because of a need to have homage done to themselves.)

Before leaving this topic, a word of caution is in order. While a waiting period of one or two hours is good, it does not follow, as some mistakenly believe, that a wait of three to six hours is better. During such a time span, certain troublesome reactions often develop, usually following the sequence of irritation, rage, depression, apathy, rigor mortis.

ONCE the neurotic or suspected neurotic patient is in your office there are various techniques for approaching him, but the basic principle, underlying all techniques, is to prevent him from expressing himself. When he is permitted to speak he should be allowed only to respond briefly to questions put to him. There are sound reasons for this dictum, the obvious one being that the patient's rambling takes up a lot of time and often obscures medical issues. It is essential that the physician never feel anxious or helpless; these emotions are reserved for patients and have the merit of producing a degree of humility and compliance which facilitates the doctor's work.

As with other aspects of the medical art, as long as one observes basic principles, he is free to vary his technique to suit his personality and temperament. In an office practice one may assume a grave, businesslike approach, or a jovial attitude with equal effectiveness, thus minimizing the patient's contribution to the exchange that takes place. Although there are infinite variations of the avoidant technique, the simple rule to follow is that you know in advance what is important to discuss. You may begin with a smile or a scowl and pointedly ask the patient what is bothering him. If he takes more than a minute to localize the complaint, a mild look of impatience toward your crowded waiting room is in order. After a short interval, you may then proceed with a series of questions which will keep things on an efficient, business-like basis.

The neurotic patient, however, is not without devices to counter these measures. He may hesitate or ramble, or he may answer the questions he has in mind, rather than those put to him. This can be a real test of strength and much ground can be lost by failure to act quickly and resolutely.

When the patient persists in talking about what is on his mind, the doctor must first attempt to ignore this and proceed with his own line of questioning. This technique is usually sufficient to impress upon the patient the irrelevance of his own ideas. But if the patient is a hard-core neurotic, something more will be called for. The doctor should acknowledge what the patient is talking about, in order to explicitly discount its significance. Most patients get the point by this time, but the doctor, wisely taking no more chances, should restructure the situation so that there will be no further opportunity for the patient to pursue his irrelevant digressions.

The goal is generally reached with the least possible expenditure of energy. It can also be reached by other techniques which require somewhat more time and energy, but permit the doctor to discharge his own tensions in an acceptable way. Such techniques include lectures, scolding or ridicule. In all cases the complaint is minimized and the patient is discouraged from repeating this behavior.

Another useful result is that by minimizing what the patient has to say and by emphasizing its irrelevance and unimportance, one concurrently induces a lowering of self-esteem in the patient. Inevitably, following Qumquat's Law*, the patient's increased self-contempt is accompanied by a raising of his respect and admiration for the doctor.

EVEN if one intends only to conduct a limited physical examination, it is best to have the patient disrobe entirely. This conveys a professionalism and thoroughness which command respect. Moreover, it has a dampening effect on verbal digressions of a personal nature. Few patients wish to bare their souls and their flesh simultaneously. But for those few whose desire to speak can surmount even THIS barrier, an examination of the throat, heart or lungs commands silence. While speech is possible during other procedures, few patients have ever been heard to utter coherent sounds during GU, pelvic or proctologic examinations.

If possible, one should avoid the temptation to engage the patient in spirited conversation during procedures that limit his ability to respond verbally. This form of behavior is suitable for dentists, who find it irresistible. The medical practitioner who emulates the dentist, however, may be forced to deal with hyperventilation, cardiac irregularities and other vegetative symptoms which the patient will use as substitutes for verbal communication. Yet, total silence may seem unfriendly and worrisome to the patient. There is a sim-

ple alternative. Instead of talking with the patient, talk about him with the nurse. (This technique is also widely effective in hospital rounds.) Comment on your physical findings as you go along, with remarks couched in such language as "Hmm, there seems to be a touch of hepatomegaly. We'll have to rule out the possibility of intraperitoneal mitotic figures." A natural flow of such conversation will emphasize your interest in the patient and relieve his sense of isolation.

BY THIS time, you probably have hit upon a diagnosis and prescribed a course of treatment. Your problems with this patient are over. If you have found a physical disorder of any sort, you will have assured him that this is his main problem. Any objections he may offer that this is not his chief concern, you will dismiss as representing poor judgment. It is more likely that he will be pleased to discover that he has a real problem, such as hives, which is causing his nervousness, and that he need not be worried about the fact that his marriage is breaking up.

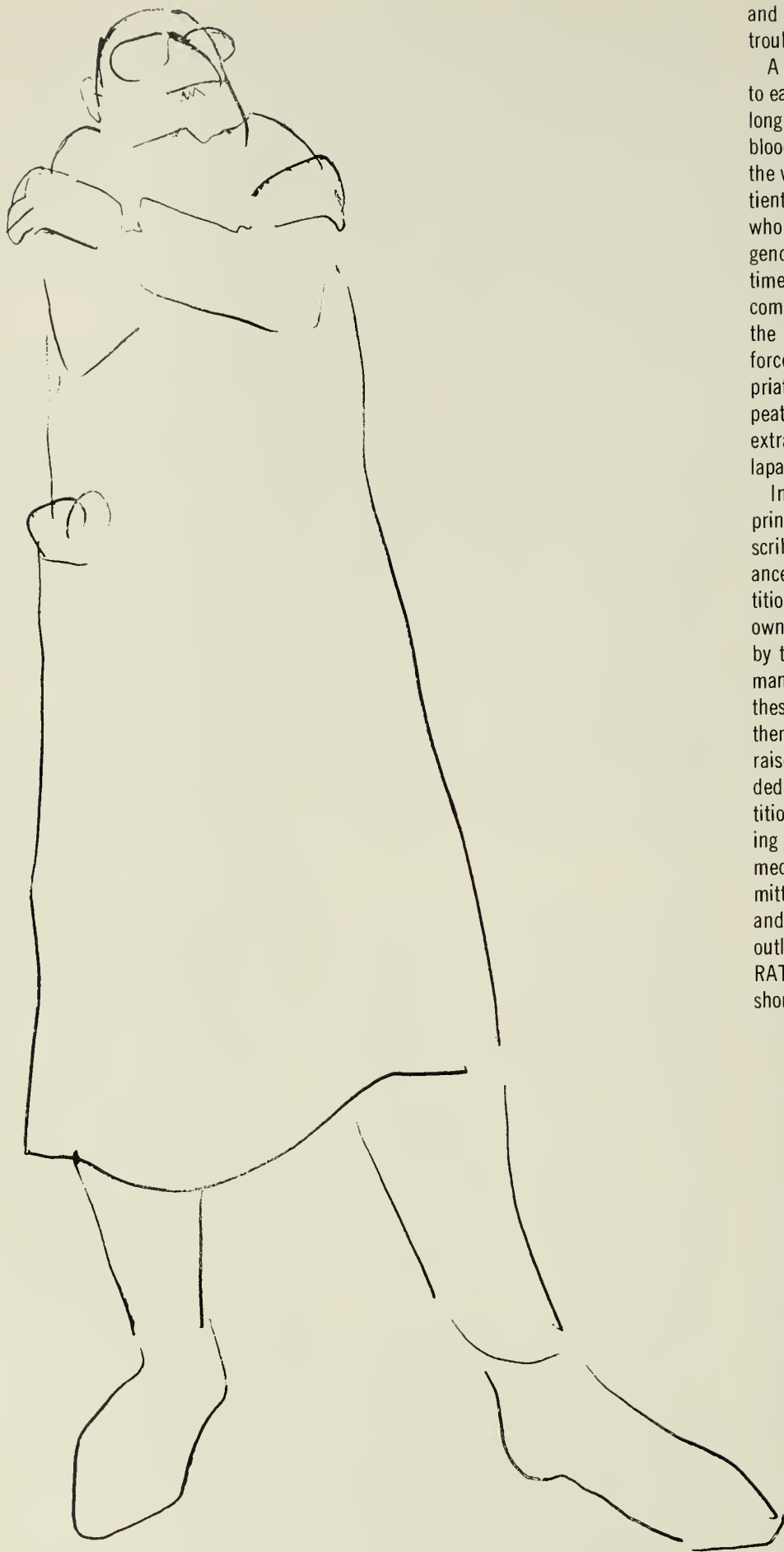
If he is a neurotic, a diagnosis might not be quite this easy and further diagnostic procedures are indicated. At this juncture, certain basic errors should be avoided. Never tell a neurotic patient that there may be something wrong which you cannot find. He already suspects this and such a statement opens a veritable Pandora's box in his imagination. Never tell him you don't know what's wrong; allow him to think you know, but aren't telling. He will admire you for this. Never tell him there is nothing wrong without doing an exhaustive work-up. After all, you really can never tell what may turn up.

It is at this stage that a poorly understood principle comes into play. In treating the neurotic, there is no sharp distinction between diagnostic and therapeutic procedures. Diagnostic procedures satisfy the need of both patient and doctor that something can be done, and often are curative. The neurotic's complaints are likely to be vague and this calls for a wide range of expensive and painful tests. While most would agree with this proposition, there are two schools of thought about the sequence and timing of these tests.

The Blitz School advocates performing all of the laboratory procedures in as short a time span as possible on the theory that none but the most hardy neuroses can survive such an experience. If the test results are all negative and the patient still complains, one may still have the satisfaction of telling him there is ABSOLUTELY nothing wrong with him and send him on his way. If you have conducted things properly, the patient should feel foolish

(Continued on page 24)

*Qumquat was a famous 16th Century psychologist.



and ashamed for having caused you so much trouble.

A more conservative approach is to respond to each new complaint as it arises, and over a long time span, run through many series of blood studies and X-rays. This helps to keep the waiting room crowded and makes the patient feel that at last he has found a doctor who never gives up. The confidence thus engendered, allied with the healing effects of time, may cause a remission of many neurotic complaints. There is, of course, the risk that the neurotic complaints will become reinforced rather than reduced. After an appropriate time span, the same tests may be repeated almost indefinitely with an occasional extra procedure added, such as an exploratory laparotomy.

In conclusion, it must be confessed that the principles and methods which have been described have not as yet received wide acceptance among medical practitioners. Most practitioners, to the patient's detriment and their own, have a tendency to pamper the neurotic by taking his verbalizations seriously. While many may occasionally blunder upon some of these techniques by pure chance, few practice them with the purpose and consistency which raises the method to a fine art. It is to a small, dedicated and widely scattered group of practitioners that we owe appreciation for developing these discoveries into a coherent body of medical knowledge which can now be transmitted to others. Now that these techniques and their underlying principles have been outlined, the young doctor is free to make a RATIONAL decision as to which course he should follow.



"Few patients wish to bare their souls and their flesh simultaneously."

ALONG THE PERIMETER

Alexander Leaf is the New Jackson Professor

Dr. Ebert has announced the appointment of Alexander Leaf as his successor to the Jackson Professorship of Clinical Medicine. Dr. Leaf will be head of Harvard's Department of Medicine at the Massachusetts General Hospital and Chief of Medical Services at the Hospital.

Dr. Leaf was born in Yokohama, Japan and received the B.S. degree in chemistry from the University of Washington in 1940. It was during his years at the University of Michigan School of Medicine (M.D., 1943) that his interest in the application of physiological principles to clinical medicine was first stimulated. In 1944, Dr. Leaf took his internship at the Massachusetts General Hospital.

After World War II, he returned to the MGH and established his own laboratory for the study of renal and fluid and electrolyte problems as part of the Medical Services. His clinical observations in hyponatremia and his experimental studies on the role of antidiuretic hormone in its production were among the first to demonstrate the existence of a volume regulatory mechanism in the body which operates independently of the known mechanisms regulating the composition of body fluids. His careful metabolic studies on man defined for the first time the consequences of excessive water retention and resulted in the recognition of clinical syndromes of inappropriate and excessive antidiuretic hormone activity that manifested the same features he had observed in experimental subjects.

In 1954, Dr. Leaf took a two-year leave of absence and went to the University of Copenhagen and Oxford. While at Copenhagen, he developed a biological system utilizing the toad bladder. This system has proved an excellent model for his studies of sodium, urea and water transport in vitro. At Oxford, he completed two significant investigations; he gave a clear explanation of why cells swell in vitro when their energy metabolism is inhibited, and he determined the efficiency of ion transport by cells and

evaluated quantitatively some of the existing theories of ion transport. He returned to the Massachusetts General Hospital in 1956, where he has continued his studies of permeability and active ion transport in living membranes.



Dr. Leaf

Dr. Leaf and his colleagues have systematically studied the mechanism of active sodium transport and its relation to metabolism in the bladder and have described the mode of action of vasopressin and aldosterone on sodium transport. He has clarified how water movement across

this model of the renal tubule is regulated by vasopressin, a study which is recognized as a fundamental contribution to endocrinology.

Dr. Leaf has long been active in the teaching and clinical functions of the department of medicine at the Hospital. His interest in medical education led him to a skillful reorganization of that part of the HMS curriculum known as the Introduction to the Clinic.

During Mayo Centennial Year in 1964, Dr. Leaf received the Outstanding Achievement Award from the Board of Regents of the University of Minnesota. The Award is given to alumni who have attained distinction in their chosen fields, and who have demonstrated outstanding achievement nationally or internationally. Dr. Leaf was a medical resident at the Mayo Foundation from 1944 to 1946.

The Jackson Chair of Medicine honors the School's first professor of clinical medicine, James Jackson. Dr. Leaf is the ninth incumbent to the Chair which has been held by: Henry I. Bowditch, Calvin Ellis, Robert T. Edes, Frederick C. Shattuck, David L. Edsall, James H. Means, Walter Bauer and Robert H. Ebert. Dr. Ebert is the third Jackson Professor to become Dean of the Medical School.

Elizabeth Zetzel Promoted

Elizabeth Rosenberg Zetzel has been promoted to associate clinical professor of psychiatry. She will continue as psychiatrist at the Massachusetts General Hospital.

Dr. Zetzel graduated from the London Institute of Psycho-Analysis in 1938 and received the M.D. degree from London University in 1941. From 1946-49 she was assistant director of the London Clinic of Psycho-Analysis. In 1950 she came to the Harvard Medical School as instructor in psychiatry. Since 1963 she has been director of the Psychotherapy Study Center at the Massachusetts Mental Health Center.

As a social psychiatrist, Dr. Zetzel has been especially interested in studying

group interaction. At a recent conference on the depressive group of illnesses, she said that women suffer more commonly from depression than men because men fail to acknowledge it. Women, generally more passive than men from childhood, have virtually no difficulty in feeling depressions, but do have difficulty in getting themselves out of them. Men, on the other hand, can mobilize against depressions but have difficulty in facing them.

Dr. Zetzel is a member of the Royal College of Physicians, the American Psychoanalytic Association, and the British Psychological Association. She is a fellow of the American Psychiatric Association and vice president of the International Psycho-Analytical Association.

New Appointments at HMS

Joseph B. Alpers, assistant professor of biological chemistry
Joseph J. Barlow, assistant professor of obstetrics and gynecology
Jonathan R. Beekwith, assistant professor of bacteriology and immunology
John L. Bethune, assistant professor of biological chemistry
Ramzi S. Cotran, assistant professor of pathology
Jan Koch-Weser '54, assistant professor of pharmacology
Edward A. Kravitz, assistant professor of neurophysiology and neuropharmacology
Susan Lowey, assistant professor of biological chemistry at The Children's Hospital
Lester Grinspoon '55, assistant clinical professor of psychiatry
Ronald A. Arky, associate in medicine
Richard E. Coggeshall '56, associate in anatomy
David S. Feingold, associate in medicine at Beth Israel Hospital
Dan Fraenkel, associate in bacteriology and immunology
Edgar C. Henshaw '56, associate in medicine
Wallace A. Jones, associate in pathology at Massachusetts General Hospital
George G. Katsas, associate in legal medicine
John A. Mills, associate in medicine at Massachusetts General Hospital
Mitchell T. Rabkin '55, associate in medicine at the Massachusetts General Hospital
James F. Riordan, associate in biological chemistry
Edward J. Sachar, associate in psychiatry
Christian Schwabe, associate in biological chemistry in the Harvard School of Dental Medicine
John McD. Tormey, associate in biophysics
Sherwin V. Kevy, clinical associate in pediatrics
Arnold H. Modell, clinical associate in psychiatry
Alfred W. Scott, Jr. '48, clinical associate in ophthalmology
John Vorenberg '54, clinical associate in psychiatry
Joseph F. Dingman, lecturer on medicine

Thermonuclear War Would Pose Ethical Dilemma for Physicians

The omnipresent potential of a thermonuclear war poses an ethical dilemma of the highest order for physicians. This dilemma was delineated by Victor W. Sidel '57, associate in preventive medicine and director of the preventive medicine unit at the Massachusetts General Hospital, during his speech at a symposium on civil defense held in conjunction with the 132nd annual meeting of the American Association for the Advancement of Science. Dr. Sidel said that nowhere is the problem more acute than in the civil defense shelter program.

What would happen if the surviving physicians were ordered to remain in shelters until post-attack radiation reached a safe level? Does the physician leave the injured to secure his own safety? How does he select the patients he will treat? How does he deal with the fatally injured; or those with incurable disease?

"Even if we omit the special problems caused by the attack . . . how could 'shelter medicine' handle the normal medical events of the country?" said Dr. Sidel. How would we deal with the four million births; the two million deaths that occur each year? . . . How would we care for the millions of people with heart disease, cancer and stroke; the hundreds of thousands who need insulin, or emergency surgery; or the 500,000 people who are in mental hospitals on any given day? . . . How would we move the aged and infirm who are in nursing homes?"

What about public health measures in the aftermath of an attack?

"The control of epidemic disease," Dr. Sidel stressed, "may constitute an overwhelming challenge. There are diseases sporadic in human populations and others in animal populations, which are kept from becoming epidemic by the most active controls. . . . How a civil defense system would handle this epidemic problem has never been satisfactorily explained."

"Shelter programs," noted Dr. Sidel, "might induce an enemy to alter his attack pattern, shifting from a thermonuclear attack to the use of chemical or bacteriological warfare."

To meet the demands posed by the threat of thermonuclear war, Dr. Sidel concluded, "the physician's responsibility

must go beyond drastic planning. As in disease, where the ultimate hope lies in prevention, so the physician must explore what to him will be a new area of preventive medicine, namely the *prevention of thermonuclear war*."

A Fourth Term for President Dammin

The Armed Forces Epidemiological Board has reelected Gustave J. Dammin as its president. This is Dr. Dammin's fourth consecutive two-year term as president. Dr. Dammin is Elsie T. Friedman Professor of Pathology and chief of pathology at the Peter Bent Brigham Hospital.



Gustave J. Dammin

Following the announcement of his reelection, Dr. Dammin disclosed the appointments of John E. Craighead and Thomas J. Gill, 3d '57, as assistants in the office of the president. Dr. Craighead, associate in pathology, will become an associate member of the Commission on Viral Infections and Dr. Gill, assistant professor of pathology, will become an associate member of the Commission on Immunization.

In January, as president of the AFEB and as a member of the Panel of Expert Consultants to the Technical Committee of the Pakistan-SEATO Cholera Research Laboratory, Dr. Dammin visited the laboratory in Dacca, East Pakistan and other installations and activities concerned with preventive medicine.

INSIDE HMS:

New Directions for Medical Education Outlined by Dr. Ebert

There is a growing awareness inside HMS of the era in which we live and learn, of the changes facing all medical students, and of the different responsibilities the public has placed upon physicians. What are the signs of the new era? What new mechanics of physician-ship will have to be developed in, say, the next decade? What will be the role of the Medical School and how can we endeavor to resolve today's problems to serve tomorrow's needs?

Last month, these and other questions were posed by Dr. Ebert in the first lecture of a series being presented by The Medical Care Club of HMS III.* Dr. Ebert's lecture was entitled, "The Role of Academic Institutions in Medical Care Planning." Before a large audience of both students and faculty, Dr. Ebert said that the stimulus for the lecture series came about directly through the students' interest in the current problems of medical care.

The series had for him "a certain historic significance," for he believes it comes at a time of great change in medicine. "We are witnessing the twilight of the Flexner Era," Dr. Ebert said, "and, in a hesitant way, we are entering a new era still uncharted and still unnamed but one that will dominate the thinking of the next several generations of physicians." By outlining today's "setting and environment of medicine" he showed that "the American public values health

and they are going to do something about it." This can be evidenced in our everyday life: on TV and radio through extensive and persuasive advertising campaigns; in newspapers and national magazines who report on the most recent advances in medicine—some of the reporting is excellent and has contributed much to public awareness of health problems; through voluntary health organizations who have learned that it is not only financially successful for them to educate the public but "through mingling with Madison Avenue they have become effective lobbyists. The result of all this has been to develop in the public, through a mixture of information and misinformation, an awareness of health problems and a feeling of expectation."

"Another part of this setting," said Dr. Ebert, "is the value our society places on research, in all spheres. One of the models that excited the imagination was the Manhattan Project, but, in the excitement of that crash program, it should not be forgotten that all the concepts about the nuclear bomb were well known . . . in medicine, I maintain, you do not build concepts with a crash program."

Voluntary health organizations have put a great deal of money into research since World War II; fellowships and societies sprung up to support the people in research, and finally, the federal programs were begun. "Part of this scene was the remarkable persuasiveness of the so-called 'retiring scientist.'" He was found to be anything but retiring when he went to Congress to seek support for his research. In time, of course, Congress became much better informed on scientific projects—they would even ask "what became of your last program?"

All this activity had an effect on universities and medical schools, "but the product of all the research activity," said Dr. Ebert, "has been an enormous increase in our knowledge of biology including human biology, and a significant increase in the understanding of the problems of clinical medicine. The only question one has to ask is not, 'was all this activity good' for clearly it was good, nor should one ask 'should it continue'; the only question one might ask is, 'at

what rate should it continue to expand and is there a time when the additional rewards are not great enough?' This is a very difficult question to ask and if the federal government or NIH did so, the screams of deans, including my own, would be very loud, but nevertheless, it should be asked."

The professional role of the physician in practice has undergone many changes. He is beleaguered by increasing demands on his time; he feels pressured to do something about his own continuing education; and he is continually faced with a massive amount of literature. Many physicians went into medicine because they felt it was possible to make significant contributions as individuals, but more and more they are expected to work with other people.

"The American Medical Association represents a majority opinion in the profession, and if one examines what has happened to the AMA it reflects what has happened, in part, to individual physicians. The AMA, in its traditional and continuing role, is regarded as the official voice of the profession. It has another quasi-official voice, as that of a lobby. It was a pretty successful lobby—up to a point. Now what I would hope is that the AMA would become the embodiment of an enlightened conservatism.

"As well as the frustration and harassment of physicians, there has been a subtle change in his social role. He is no longer considered to be quite so important in forming an opinion—he is also considered to be somewhat less than infallible on social positions."

Dr. Ebert then turned to the pre-Flexner era. In understanding the past we are helped in understanding why we have the feelings we do about today's medical education and science. He said that in a little more than a century the U.S.A. and Canada produced 457 medical schools. One hundred and fifty-five of them survived until 1908. When President Pritchett of M.I.T. joined the Carnegie Foundation he commissioned Abraham Flexner to make a study of American medical schools. For a year-and-a-half Flexner visited schools around the country. "The schools welcomed him because they knew he came from the Foundation and they thought he had

* Two years ago a small group of students in their first year at HMS decided to form a public health club. Now in their third year, the students have chosen to name their club, The Medical Care Club of HMS III. They hold small, informal meetings once a fortnight. But now, because general interest has increased, HMS has helped them to organize five major lectures dealing with various aspects of medical care. These lectures will be held once a month in Amphitheatre D, HMS. The other speakers will be: Mr. Marion Folsom, former Secretary of Health, Education and Welfare, "Planning Health Care"; Dr. William H. Stewart, Surgeon General USPHS, "Government's Role in Medical Care"; Dr. Herman M. Somers, Professor of Politics and Public Affairs, Princeton University, "Financing Medical Care"; and Dr. Alonzo S. Yerby, Commissioner of Hospitals, New York City, "Medical Care for the Disadvantaged."

come to give them money. There were, therefore, doubly disappointed when he brought out the really scathing and now famous Report No. 4 in 1910."

A number of reforms followed the Flexner Report: proprietary schools closed down; schools sought association with universities, and those who were associated sought closer bonds; the idea developed that medical schools needed full-time faculties for clinical departments; specific premedical requirements were changed. The result of all this was minimum production of doctors, it became a question of quality vs. quantity. "The focus of medicine became one of understanding mechanisms of disease and developing a closer relationship with basic science departments—all the things we see today.

"What are the problems facing medicine today, given this setting and given this kind of background in medical education?

"There are too few physicians for the number of patients as medicine is practiced today.

"The organization of care offers problems. Traditionally, the doctor's office was the place where problems could be handled." Today, in increasing numbers, patients prefer to go to hospitals.

"There has been a lack of hospital planning. Optimal size for a hospital to meet its communities needs has been disregarded." There has been duplication of facilities.

"Payment for care has presented problems. Through the development of insurance—which covered hospitalization, the most expensive part of medical care—patients tended to use the hospitals more because their stay was paid for. This created an unrealistic use of hospitals. Gradually the concept of insurance and prepayment has been effected and the idea was fostered that perhaps one ought to pay for the whole gamut of medical care."

Community hospitals have had the opportunity to be essentially paid for by insurance carriers, but voluntary and city hospitals have particular problems. The voluntary hospitals contend with large loads of patients paid for by welfare, and city hospitals, being a public service paid for through taxes, never seem to have enough money available to them.

"There has been no rational distribution of doctors or facilities within a city or between a city and its rural areas." There are shortages in other areas of

medicine, particularly in nursing.

"What could be the role of the medical school in all this? What can we do?

"We can create an environment for inquiry into the problems of medical care. The business of the medical school, in the traditional sense, was to teach medical students scientific medicine and advance science and supply the country with doctors, but not to be very concerned about what happened to them when they left school. It is evident that this posture can no longer be maintained, and indeed, no one wants to maintain it."

As part of the university can a medical school change? Dr. Ebert felt it could because universities were viable institutions and medical schools have changed in the last 25 years by developing into large research establishments.

"What can medical schools do to create the change?

"First, there has to be a recognition by the faculty of the importance of the problem, and the problem obviously is: can we do something about providing the kind of care we know we can give to a large number of people?

"Another thing schools can do is recruit, in a substantial way, help from those working in the social sciences. In the area of economics and sociology there can be a very important impact upon the study of the problems of medicine and particularly of how it is delivered." We need economists and sociologists working not as servants in clinical departments but independently in examining the problems.

"There needs to be a new force in the clinical faculty involved in the problems of care. This is going to be a kind of hybrid physician, one who is basically a person with an interest between public health and medicine; who is going to be concerned with care of patients but who also is going to look at it from the point of view of a person informed about and concerned with the community and its problems.

"Schools can influence the training programs developed in the NIH and USPHS.

"We can modify and have an impact upon the medical school curriculum, more by the kinds of people and kind of environment in which we teach than by a juggling of courses.

"We can redefine the role of teaching hospitals in a way that needs to be done." They should be concerned not only with the acute curative aspects of disease but also with the total care for a group of

patients. "Such hospitals could then be looked at in terms of teaching opportunities as well as becoming models for other communities. This must be done in a way that can be replicated. It cannot be done with, say, 15 doctors to two patients. It should be done in a way that is applicable to the community.

"As a part of this one might develop close relationships with hospitals on a regional basis to whom, eventually, the same kind of experiment might be extended.

"We will have to become involved in the regional planning of facilities for either city, state or region. This means an exchange of people between hospitals and in our becoming involved in the continuing education of doctors.

"All of these opportunities become an important part of the role of the Medical School and teaching hospitals, and they will become the next step in the future.

In conclusion Dr. Ebert said, "I think there are a number of signs that we are in a new era, as evidenced by the Coggeshall Report, the White House Conference on Health, recent legislation on Medicare and, more importantly, on Heart Disease, Cancer, Stroke and Related Diseases. While that bill may have been conceived in one way—to develop even larger centers in medical schools—now, as a piece of social legislation, it is being conceived primarily as a way to do regional planning.

"The Flexner Era has accomplished much and there is no need to sacrifice the best of it. Medical research must continue, the specialties of medicine fostered and quality maintained. But there must be a new dimension. The medical establishment, led by the medical schools, must attack with vigor the most pressing medical problem of our time; how do we provide all of the people with the quality of care which it is ours to give?"

HMS II Innovates Curriculum Change

The curriculum at HMS is subject to constant evaluation by everyone from the most august professor to the most disgruntled undergraduate. In the last weeks of 1965, the process took a rather new turn. About two dozen students in the second year class proposed an educational experiment and volunteered them-

selves as the subjects. They proposed a plan in which the pathophysiology course would be regarded as an opportunity to do independent study on topics covered by the formal course. (For second year students, the pathophysiology course occupies 75 percent of their time.) Instead of routinely attending lectures, the group proposed to cover the same topics through guided reading and small group discussions. Laboratory work would be continued but on a streamlined basis.

To accomplish their plan, the students requested permission to shift, as a group, to one laboratory room. They also asked that the laboratory instructors for each section of the pathophysiology course be informed about their independent study group, and whether volunteer instructors, interested in their approach, could be solicited for the experimental room. The group accepted full responsibility for learning course material and passing the required examinations.

Conferences were held with Dr. Ebert,

Dr. David Freiman, coordinator of the pathophysiology course, Dr. Alexander Leaf, chairman of the standing committee on the medical curriculum and Dr. Joseph Gardella, dean for student affairs; these conferences resulted in acceptance of the students' proposal.

Some members of the group innovating the change argued that at HMS they are so overtaught that they have little time or energy left to learn. Others placed emphasis on the importance of learning actively because they felt that the excessive number of lectures and cook-book laboratory sessions resulted in passive, and unprofitable, learning.

For the purpose of pursuing these different learning methods, two dozen students have split up into groups of six to eight. As a whole the group agrees that, in the short run, flexibility is their greatest asset and that, in the long run, the most important task is to discover, through exploration and experiment, what methods best induce learning.

A Department's Focus

In this issue Dr. Ebert generously permitted HMAB to publish the most significant portions of his lecture, "The Role of Academic Institutions in Medical Care Planning." Although this was the first in a series of major lectures to be given this Spring by The Medical Care Club of HMS III, its importance also served to emphasize and reiterate the Medical School's teaching and thinking about today's problems in social medicine. Since 1947, all third year students have been exposed to a course focused on contemporary problems in social medicine given by David D. Rutstein '34, Ridley Watts Professor of Preventive Medicine, head of the Department, and Osler L. Peterson, Visiting Professor of Preventive Medicine, and their associates. Many of the problems posed by Dr. Ebert are being studied by the Department today. In a future issue HMAB will present an article about other aspects of work being done in the Department.

Second Year Show: "The Spy who came into The Fold"



This year's show was yet another fine parody within a parody on, of course, The School. Undoubtedly the plot was understood by the discerning and discriminating few, but the performance, being a lively one, was thoroughly enjoyed by entertainers and audience. *Left: Dr. ? played by Paul N. Seward. Below l. to r: Richard A. Marks, David L. Pearle, David H. Sachs, Deborah L. Baron, Charles M. Trauring. Dog played by Ronald O. Rieder.*



Enthusiastic Audiences Help to Launch a New Lecture Series on History of Medicine

In December the Harvard Medical School sponsored the first lecture in the newly initiated series on the History of Medicine. The series has been organized by Dr. Ebert.

A large and enthusiastic audience filled the Countway Library auditorium to hear I. Bernard Cohen, Professor of the History of Science at Harvard University, give the first lecture on the lives of three 17th Century scientists, Johannes Kepler, Galileo Galilei and Isaac Newton. Professor Cohen discussed the impact made by the different personalities of the three men upon the scientific, ecclesiastical and political thought of their day.

Kepler, the astronomer-mathematician saw as his mission the tying together of all elements of knowledge in order to unravel the mysteries of the universe. He valiantly attempted to explain theological dogma in terms of scientific thought and investigation. Galileo supported the Copernican theory and incurred the wrath of the Church during the days of the Inquisition. He was described as one of the earliest scientists to use mathematics and reasoning, rather than induction from experiments, to solve the physical problems imposed by his observations. As a scientist, Professor Cohen said he took the greatest pride in Newton, and portrayed him as the brilliant, but rather uncommunicative mathematician-scientist, whose reluctance to provoke controversy led to delays in the promulgation of his theories concerning the physical forces at work in the universe.

The second History of Medicine Lecture, "Philosophy and Experiment in 19th Century Physiology" was given by Everett I. Mendelsohn, Associate Professor of the History of Science at Harvard University. In a word of apology, Professor Mendelsohn explained that his concept of the 19th Century really started in the 17th and ended in the 20th Century.

He turned first to Jacques Loeb*, then of the Rockefeller Institute for Medical Research. Early in the 20th Century, with little or no factual basis, Loeb predicted that the major advances of the future in physiology would be in the chemical delineation of the chromosome.

Thus, he foresaw one of the great discoveries of present-day physiology.

Then, in an abrupt turnaround, Professor Mendelsohn back-tracked three centuries to William Harvey and René Descartes. He equated the significance of Harvey's treatise on the circulation of blood, which characterized the heart as a muscle, with the boldness of the concepts advanced much later by Loeb. He then cited Descartes attempts to discredit Harvey, by advancing the theory, based on the known chemistry and physics of his time, that heat was responsible for

the motion of the heart. The controversy, Professor Mendelsohn noted, was typical of the struggles between the "vitalists" and the "mechanists" in their attempts to explain the biology of living things.

Professor Mendelsohn gave major credit to Hermann von Helmholtz for lifting physiology from its mired trough. It was von Helmholtz, German physician, anatomist and physiologist, who, with his associates at the Physical Society of Berlin, advanced the concept that all forms of energy obey certain fundamental laws.

First Laurence B. Ellis Lecture

It is not often that a teacher still on the active staff of an institution is honored by having a lectureship established in his name. But such a man is Laurence B. Ellis '26, clinical professor of medicine, and director of the electrocardiograph laboratory, chief of the cardiac clinic and visiting physician at the Boston City Hospital.

On November 5, 1965, the first Laurence B. Ellis Lecture was given at the Boston City Hospital by Dwight E. Harken '36, clinical professor of surgery. Dr. Harken, a long-time professional and personal friend of Dr. Ellis, spoke on "Heart Surgery—Legend and a Long Look." The Lecture was divided into three sections: the general difficulty of awarding precise credits of origin for specific pieces of work; how Dr. Ellis' long look at surgical results has con-

ditioned the present and future work in the field; and finally, the utilization of such scrutiny for Dr. Harken's design of a new heart valve. He then described his long and fruitful association with Dr. Ellis. Dr. Harken operated on 1000 patients using the closed technic, but it was Dr. Ellis who took the "long look" lasting ten years for each of the patients. It was this remarkable follow-up study, Dr. Harken said, that led to the era of open heart surgery.

Dr. Harken concluded by paraphrasing Jonathan Swift—We see so far because we stand on the shoulders of giants. "There is a personal awareness of the fact that modern heart surgery has been able to go far because we have stood on the shoulders of giants. We thank you Dr. Ellis for offering such shoulders."



Dr. Ellis



Dr. Harken

* Father of Robert F. Loeb '19 and grandfather of John N. Loeb '61.

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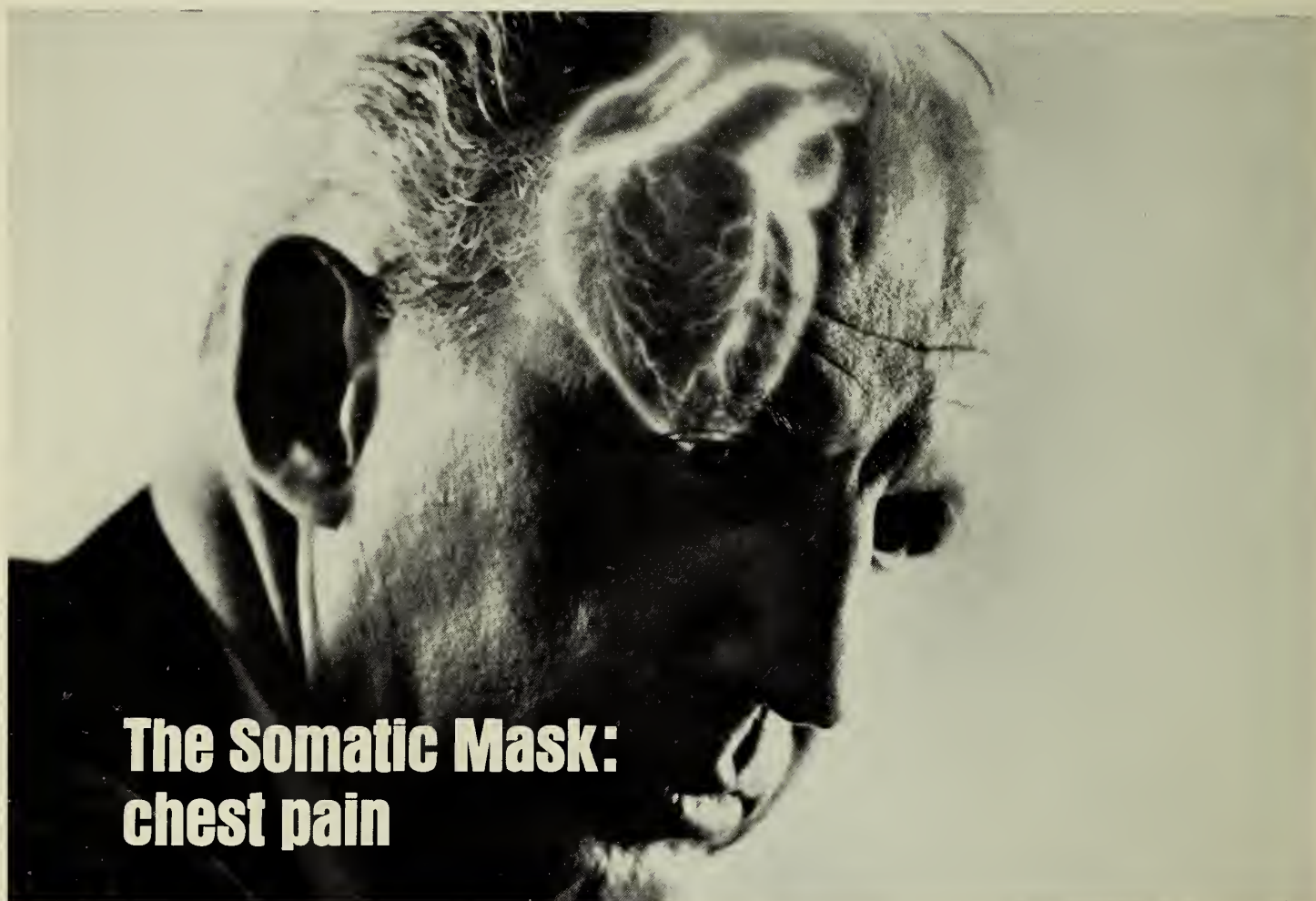
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